A Psychiatric Resident's Struggle with Anorexia

My mental health deteriorated significantly during my third year of medical school. The stress of rotations, the schedule, and the academic pressure built up and on the background of recent trauma—a near-fatal motor vehicle collision that resulted in prolonged hospital stays for two friends—it was the perfect storm. By the end of the year, I knew something was off and made an appointment at the medical school's counseling center.

Working with a psychologist there for months resulted in diagnoses of PTSD, anxiety, and depression. Cognitive processing therapy and exposure-based therapy dramatically reduced my symptoms, though I believed the diagnoses to all be overreactions to my current situation. Before we could nicely wrap up the therapeutic relationship, I left for away rotations and residency interviews. Hidden beneath the depression, anxiety, and PTSD was an ill-conceived coping mechanism—dietary restriction coupled with over exercising. I hadn't lost much weight, but when it came up I explained it away as a result of a better diet and more time spent in the gym.

In the months that I spent away, everything worsened. While I once believed that I was just following a healthy diet, I was increasingly aware that my relationship with food and activity was abnormal, though I wouldn't admit that to myself much less to anyone else. When I returned, I looked like a different person. I had lost over a third of my body weight. My diet had become increasingly restrictive over the course of the two previous years, both in terms of the type and quantity of food I ate. I regularly over- exercised and used exercise to compensate for eating "too much." I made myself vomit. I chewed and

spit out food. I didn't deny the fact that I lost some weight, which seemed to throw off concerned friends and classmates who noted physical changes, and I continued to offer the same excuses about my increased time in the gym and my focus on a healthier diet.

Fortunately, my primary care provider heard the concerns voiced by others, noticed the physical changes, and directly confronted me. Being open about the behaviors I was engaging in was incredibly difficult. I spent most of the appointment looking intently at the floor, and if I hadn't already had a good relationship with her, I don't know if I would have been able to share as much as I did. She worked with the psychologist I had previously seen and started building an outpatient treatment team. I vehemently refused treatment at a higher level of care—after all, I knew which hospital systems were covered by my insurance, and I was aware of the overlap with my top ranked residency. I was similarly hesitant to involve a psychiatrist in my care. If I matched to my first-choice program, then I would likely interact with whomever my psychiatrist was as a resident. More rational minds prevailed, and a psychiatrist who was only peripherally affiliated with the residency program was added.

Eating and food-related behaviors and mood and anxiety were the dominant theme of my last year of medical school. I spent a tremendous amount of time in appointments. At times I was seeing my psychiatrist, psychologist, and primary care provider weekly. Group therapy was added because I needed more support, and I was still refusing to consider a higher level of care. The flexibility afforded by the final year of medical school meant that I was able to make my appointments without taking formal medical leave or making my school aware of what was going on. Like considering a

higher level of care, I refused to consider medical leave. Anything other than graduating on time with the rest of my class was unfathomable. I worried about the impact that my psychiatric diagnoses could have on my future career, and believed that having to explain medical leave would only highlight my medical history going forward. Instead, I changed my schedule and opted for rotations with a reputation for minimal work hours.

When match results came out, I did match to my top choice program with which my psychiatrist was affiliated. It was a relief to not worry about finding new providers, but there was still some transition in my treatment team. A therapist with a background in eating disorders, as well as a dietician specializing in eating disorders, were added and I stopped seeing the generalist psychologist. I was terrified of being identified as the "anorexic, depressed psychiatry intern" and at the same time the eating disorder identity had become so important to me that I was terrified of recovery and losing that piece of myself. Contrary to my opposition to the diagnoses of PTSD, depression, and anxiety, once I was willing to admit that I had a problem with food I embraced the diagnosis of anorexia. It validated how sick I was, and I associated the label with extreme dedication and self-control.

As a medical student, when patients expressed familiar sentiments regarding their past traumas or their mood, I desperately wanted to share that I had a deeper understanding of the sense of guilt, responsibility, and pain that they related. But I knew it was not my place and not appropriate. This was only magnified when I became an intern. I routinely outscored my patients on depression screeners. My SSRI dose was

higher than many of my patients. When a patient with an eating disorder was on the unit, I was aware of their behavior use, despite the fact that my team was not caring for them. During morning conferences, the judgments and discussions around diagnoses and behaviors that I shared with patients were hard to sit through. More than once, I desperately wanted to share my perspective, talk about the weeks when I found it impossible to get up and actually do anything, or the profound guilt and failure associated with successfully following my meal plan. When I watched my patients discuss their own relapse prevention plans, I inwardly compared aspects to the plan that my therapist and I had updated only weeks previously. After a senior resident commented on my lunch a few times, I wanted to burst and scream that I had an eating disorder, that I wasn't just eating healthily, that there was a meal plan that I had to follow.

When discussing PTSD treatment modalities, I wanted to share my experiences, but I was afraid of crossing boundaries. Interns do not have access to supervision in the same way that senior residents do, so I had no one to talk to about these concerns—self-disclosure, over-identifying—without revealing a significant amount of personal information. I was hesitant to spend time in my own appointment sessions discussing these issues when I was still actively struggling with disordered eating behaviors, low self-esteem, and depressed mood. I was aware that I was not well enough to carry a patient who was engaging in disordered eating behaviors and wondered how I would handle it should I be assigned such a patient. I dealt with this daily, in addition to trying to follow my meal plan and practice my skills.

Despite my intern schedule I still needed to attend group therapy, individual therapy, and psychiatry appointments weekly, see my dietician twice a month, and see my primary care provider at least monthly, all on top of the PRITE (the annual in-training exam for psychiatry residents), licensing exams, residency academics, being on call, and the months of medicine that are required of all interns.

It was an exhausting and isolating experience—being an intern and having mental illnesses that I struggled with daily. I felt there was so much stigma around mentally ill providers that I avoided reaching out for support from my residency for fear of gaining a label that would follow me for the rest of my career. I longed for the kind of clarity on connecting and relating to my patients that could only come from having a discussion with someone who knew my whole story. While I no longer looked anorexic and depressed when I started my intern year, my disease was by no means cured. I soon resented the fact that I did not wear that label at work. The fact that I no longer looked ill amplified the emotions and behaviors that I struggled with because I felt as if I had to prove to myself and others that I still needed the intensity of treatment I was receiving. No one understood how significant it was that I ate a potluck lunch at academic gatherings. When I said I had a bad weekend, no one could guess that it meant I spent it lying on my living room floor, wishing I might fall asleep and never wake up again. I couldn't share my struggles and successes with my colleagues because I worried what that information could do to my future as a psychiatrist.

I was lucky to have supportive care providers throughout this time and currently. Despite the support, I still wrestle with over-identifying and the urge to self-disclose—both with my patients and with my colleagues. I struggle with my diagnoses every day. I am not recovered, but I believe full recovery is possible. I know that I have a unique perspective on mental illness. As a resident I'm regularly challenged to find a way to incorporate my knowledge and perspective into my practice, and I am sure this challenge will continue for the rest of my career. I know it can make me a better psychiatrist, but only if we change our approach to how we regard providers actively struggling with mental illness.

The author is a female psychiatry resident in the United States.

COMMENTARY:

Commentary on "A Psychiatric Resident's Struggle with Anorexia"

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In this piece, the author gives a poignant account of how isolating and painful it can be to experience mental health problems while in medical training. She became symptomatic in medical school and did not immediately receive treatment. We know that medical students experience higher rates of mental illness than age-matched controls - even though they start their training with lower rates of burnout and depression (Brazeau et al. 2014) - and are less likely to access appropriate help when this happens (Grant et al. 2015). Indeed, even when the author did engage in treatment, the level of care was not initially adequate for her needs. This was not necessarily due to lack of access to care, but rather due to reticence to receive such intensive treatment. Barriers to appropriate care in the author's case included concerns about stigma, confidentiality, and time constraints. These are similar to findings in the literature that explore medical trainees' reticence to seek help (Moutier et al. 2009). We observe here a quality of courage and fortitude as this medical student, now a resident, perseveres in her professional work.

Fortunately, there has been an increased focus in recent years - in both the general media as well as the academic literature - on exploring and addressing challenges to optimizing physician trainee mental health (Baker and Sen 2016). The Accreditation Council for Graduate Medical Education (ACGME) has recognized the need for improved wellness among physicians-in-training, and have recently announced a commitment to ensure that this is an integral part of training and the culture of the learning environment (Daskivich et al. 2015). In 2017, major additions were made via addition of a robust section in the ACGME's new proposed Common Program Requirements (CPR) which both specifically acknowledges the elevated risk among

trainees as well as addressing the need to promote well-being. The ACGME has created a Physician Well-Being web page (http:/www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being), which includes content for key areas to facilitate physician wellness (including resources, education, and research, among others).

Academic clinicians within the field have also proposed and developed multi-tiered interventional approaches to address the mental health needs of medical trainees (Baker and Sen 2016, Grant et al. 2015, Sharp and Burkart 2017). More research is needed to refine these models, but the hope is that we have begun to engage in a productive scholarly conversation as a community, and that there are more comprehensive solutions in the works so that trainees such as the author of this submission will no longer need to suffer in silence.

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