

# The GW Psychiatrist

OUR GEORGE WASHINGTON UNIVERSITY  
PSYCHIATRY RESIDENCY – WHAT MATTERS MOST

Dr. James Griffith

**The most distinctive** feature of our GW psychiatry residency is its commitment to psychiatric humanism that is grounded in empirical neuroscience. Psychiatric humanism places a patient as a person – not the patient's disorder – at the center of treatment.<sup>1</sup> This difference matters because we treat patients in an era when American psychiatry has been increasingly defined, both within the profession and outside it, as a medical specialty focused narrowly upon pharmacological treatment of psychotic, mood, and anxiety disorders.

Psychiatric humanism is committed to

evidence-based treatment for mental disorders, which requires a high level of psychopharmacological expertise. This is essential since active symptoms eclipse and erase the person who bears them. However, psychiatric humanism extends beyond symptom remission in its aims to relieve suffering more broadly, including suffering from loneliness, demoralization, grief, spiritual crises, and other "normal" syndromes of distress. Often this "normal" suffering weighs more heavily upon our patients' lives than do the symptoms with which we diagnose

*(Continued on page 2.)*

## Table of Contents

- 1-2 The Chair's Column
- 2 From the Residency Director
- 3 Chief's Corner
- 4 Forensic Psychiatry at GW
- 5 Faculty Highlight
- 5 Psychosomatic Medicine
- 6-7 Inova Fairfax Hospital
- 6 Children's National Medical Center
- 7 Building Therapeutic Alliance
- 8-9 On-Call in the Winter
- 9 The Greatest Love of All
- 10 Book Review
- 10 Resident Publications & Presentations
- 10 Kudos & Congrats
- 10 Welcome & Good-bye



*Photo: 12th Annual Wiener Memorial Lecture Grand Rounds.*

*Left to right: Karen Wooten, Bruce Shaver, Sally He, Stefani Reinold, Jenny Yi, Dr. James Griffith (Chair), Dr. Thomas Insel (Director of the National Institute of Mental Health), Stephanie Cho, Nicole Nguyen, Jason Emejuru, Gathi Abraham, Ross Goodwin, Amanda Holloway.*



# FROM THE RESIDENCY DIRECTOR

Dr. Lisa Catapano

## Happy recruitment season!

One of my favorite things about interview season is listening to applicants talk about what stands out to them about our program. Of course I hear a lot about the many training experiences we offer and the allure of D.C., but the compliment I hear most often (and am most proud of) is how impressed they are with our community of residents. Our residents dedicate a huge amount of time in these months to lunches, dinners, and tours with interviewees, and it certainly communicates to the applicants how committed our residents are to the program. I also think that in a program like ours, which is so heavily team- and community-based, getting a good sense of who our residents are is more important than learning about any particular rotation or training opportunity.

Thanks to everyone for the many hours you have put in to recruitment so far. The feedback I have been getting from the applicants is that it is greatly appreciated by them.



## GW RESIDENCY — WHAT MATTERS

(Continued from page 1.)

their illnesses.

Psychiatric humanism means getting to know a patient with schizophrenia as a person who yearns to be acknowledged and understood as a human being, not just as a tangle of psychopathology. We cannot cure schizophrenia. However, we can provide compassion and accompaniment so that a person who is psychotic need not traverse this barren and threatening journey alone.<sup>2</sup> Helping a patient to recover a worthy life requires skill sets whose emphasis in our curriculum distinguishes our residency curriculum from many other programs. Some of these include:

- Creating collaborative therapeutic relationships that build upon patients' strengths, competencies, and learning from lived experiences.
- Conducting treatment within the family and cultural contexts of patients' lives.
- Aiding recovery from grief, demoralization, and other normal syndromes of distress.
- Accessing a patients' spiritual resources in order to

strengthen resilience.

- Conducting therapeutic dialogues that help clarify sources of identity, meaning, and hope.
- Conducting focused psychotherapies that achieve their objectives with efficient use of time and money.
- Using medications to strengthen capacities for communication and relatedness with other people.
- Tailoring effective strategies that counter stigma, prejudice, and social injustice.

Each year, the new PGY-I class whom we recruit through the Match consists of medical students whose values and commitments motivate them to become this kind of psychiatrist and physician.

### References

- (1) Griffith, J. L. (2014). Neuroscience and humanistic psychiatry: A residency curriculum. *Academic Psychiatry* 38:177-184.
- (2) Weingarten, K. (2012). Sorrow: a therapist's reflection on the inevitable and the unknowable. *Family Process* 51:440-455.



# CHIEF'S CORNER

Dr. Elizabeth Greene

Terrorism and decapitations by ISIS. Civil war in Syria. Malaysia Airlines flights 370 and 17. The Russia-Ukraine conflict. Mass shootings at Ft. Hood and UC Santa Barbara. The Israel-Palestine conflict. Super Typhoon Rammasun in the Philippines. Ebola. Eric Garner. Michael Brown.

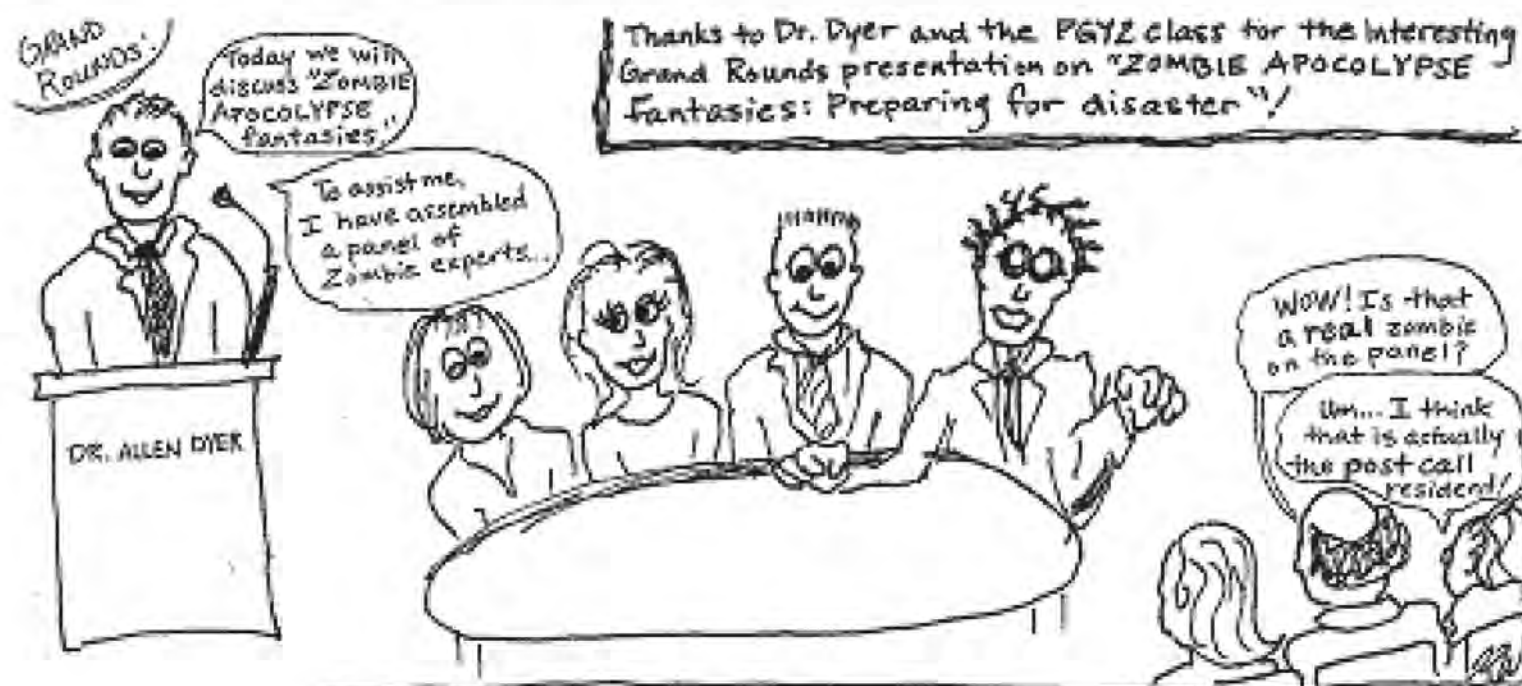
Looking back at 2014, it's no wonder our patients come to us feeling depressed, anxious, paranoid, or reluctant to face tomorrow. They come to us looking for hope, peace of mind, and faith that things will get better. While this seems like a daunting task, from my unique perspective as Chief Resident, I can confidently say that our department, and especially our residents, is making a difference in the troubled lives of those around us.

Just the other day, I did something so simple as to return a call from a patient who was looking to get into our resident clinic. "Wow, thank you so much for calling me back," he gushed. "Do you know how hard it is to get mental health-care? If you're not suicidal or living on the streets, you've got nowhere to go! And now to hear back not just from someone at a clinic, but from an actual psychiatrist – wow,

amazing!" I hadn't even accepted the man into our clinic, and already he was so appreciative of our care. I hear similar remarks throughout my time screening patients for the resident clinic. Often simply returning a call or setting up a future appointment offers just enough of a much-needed glimmer of hope. I'm sure most of your patients are not profusely thanking you for your service, so I wanted to take the time to share with you that despite the numerous tragedies happening in the world around us, what you're doing – even the "small" things, like returning calls or filling out paperwork – really matters.

I know that on my tough days, when I'm feeling overwhelmed by notes and administrative duties, insulted and enraged by a narcissistic patient, or pushed to my limits by a willful 3 year old and clingy 1 year old, I can turn to my co-residents and supervisors for hope and relief. Whether it's mooching chocolates from my office neighbor, Nicole; sitting in on an education committee meeting with Jenny, Pooja, and Steph Cho; discussing ways to make recruitment better with Ross, Linda, and Bruce; working on this newsletter with Sally, Karen, and Stefani Reinold; or checking in with the interns to help keep them afloat, I can count on my colleagues to lift my spirits and give me purpose.

I hope that despite this year's news reports, you will all remain hopeful, forward-thinking, and thankful. Here's to a happy and healthy 2015!

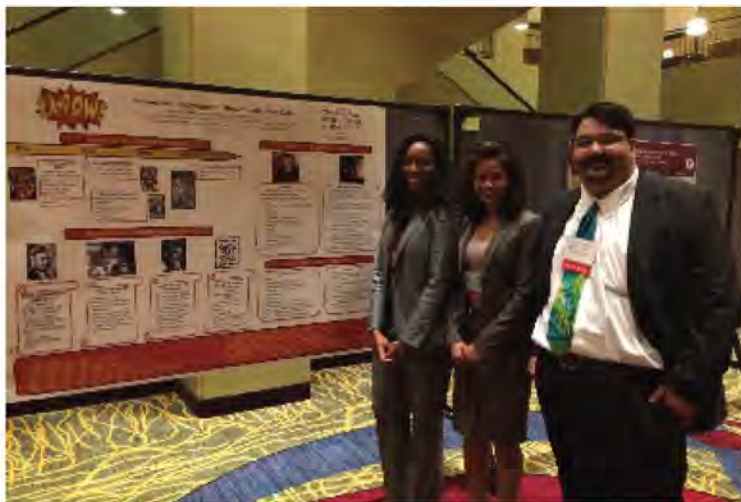


Drawn by Karen Wooten



# FORENSIC PSYCHIATRY AS A DOMAIN OF EXCELLENCE IN A GENERAL PSYCHIATRY RESIDENCY PROGRAM

Dr. Eindra Khin Khin



*Photo: American Academy of Psychiatry and the Law Annual Meeting. Left to right: Darlinda Minor (PGY-III Resident), Dr. Eindra Khin Khin, Rushi Vyas (PGY-III Resident).*

**Forensic psychiatry**, the interface of psychiatry and the law, is a core competency training area in psychiatry residency education. The Forensic Curriculum at the George Washington University Psychiatry Residency Program offers progressive exposure to forensic concepts and practices most relevant to general psychiatry residents.

Starting with the PGY- II year, residents are introduced to fundamental principles and practices of psychiatry as they apply to legal issues. In didactics, they are taught by both medical and legal personnel, who are well versed in confronting complex medico-legal issues, to offer valuable and diverse perspectives. In the PGY-III and -IV years, residents with an interest in forensic psychiatry are afforded an opportunity to further pursue various forensic electives. Under the tutelage of the forensic supervisors, residents learn first-hand about forensic processes, including doing a thorough document review, conducting a forensic evaluation, writing a report, communicating with the legal team, giving a deposition, and testifying in court. Such electives and experiences help residents translate didactic knowledge into practical applications in both clinical and legal settings.

This academic year, we conducted mock trials for the first

time as part of our Forensic Curriculum, in conjunction with the faculty members from George Washington University Law School and Saint Elizabeths Hospital (SEH) Forensic Psychiatry Fellowship, to further enhance the practical educational experiences. In this simulated courtroom environment, residents learn to present testimony in court on selected civil and criminal forensic topics such as disability assessment, competency to stand trial, and criminal responsibility.

In addition, our residents presented multiple academic projects at the American Academy of Psychiatry and the Law annual national meeting in October 2014. The topics ranged from institutional liability in college suicides, decisional capacity issues in Amyotrophic Lateral Sclerosis, and serial killers who are healthcare professionals, to public mental health implications of comics.



*Photo above: Mock Trial at GWU Psychiatry Residency Program. Left to right: Brittany Sheehan (SEH Post-doctoral Forensic Psychology Resident), Khalid Abubaker (SEH Forensic Psychiatry Fellow), Phillip Candilis (SEH Forensic Psychiatry Fellowship Director), Peter Meyers (GWU Law Professor), Eindra Khin Khin (GWU Forensic Psychiatry Services Director), Darlinda Minor (GWU PGY-III Resident).*



# FACULTY HIGHLIGHT: DR. CRONE

## Dr. James Griffith

**Dr. Cathy Crone** is one of the few females to ever become the President of the Academy of Psychosomatic Medicine, the academic home for psychosomatic medicine and consultation-liaison psychiatry as medical sub-specialties.

Dr. Crone is Vice-Chair of Psychiatry at Inova Fairfax Hospital, Associate Professor of Psychiatry at George Washington University, and Program Director for the George Washington University/Inova Fairfax Hospital Psychosomatic Medicine Fellowship. Her APM presidency adds stature to her already extensive record of leadership in psy-

chosomatic medicine that has included the Psychosomatic Medicine Committee of the American Board of Psychiatry and Neurology, the ACGME Psychosomatic Medicine Milestones Committee, and Scientific Program Committees for both the American Psychiatric Association and the American College of Psychiatrists.

Dr. Crone directs the GWU Psychosomatic Medicine Fellowship, based at Inova Fairfax Hospital, which has trained fellows for well over 30 years. Numerous graduates of the GWU Psychosomatic Medicine Fellowship have become psychosomatic medicine re-

searchers and academicians in their own right.

Dr. Crone's own clinical focus has been organ transplantation and gastrointestinal disease, about which she has authored numerous journal articles and book chapters. Her expertise extends to end-of-life care, psycho-oncology, and psychological adjustment to medical illness. She has long been a dedicated mentor, educator, and fellowship training director within Psychosomatic Medicine.

Her greatest joy is time with her family, husband Nathan and son Evan.

## PSYCHOSOMATIC MEDICINE INTEREST GROUP

Dr. Stephanie Cho, Dr. Fatima Noorani, Dr. Rushi Vyas

**Have you ever wondered** what happened to the intriguing case you admitted or managed on call? Do you have questions about the presentation and management of challenging cases that you were unable to follow to completion? If you answered "yes" to any of these questions, then the Psychosomatic Medicine Interest Group (PMIG) might be for you.

A motivating factor for creating the PMIG was to have a forum for discussing interesting and challenging cases with peers, faculty, and experts in the field. The group consists of local psychiatry residents (currently from GW, Walter Reed, and St. Elizabeth's) and

medical students interested in psychosomatic medicine. We meet on the last Thursday of every month, at the MFA, under the supervision of the current

PM fellows in addition to Drs. Crone, Gandhi, Griffith, and Norris.

Reflecting back as we approach PMIG's one year anniversary, we realize that the group has helped us to enhance our diagnostic and management skills by analyzing complex cases with more experienced

clinicians. Moreover, it has provided a forum to discuss challenging systemic issues and explore more comprehensive solutions. Looking ahead, we

would like to continue being a sustainable resource to those interested in psychosomatic medicine by connecting them with mentors in the field. We would also like to expand the group by having more involvement from medical students, residents, and faculty as participants or guest speakers.

We would like to express our appreciation to faculty and former PM fellows who have provided their support and supervision thus far: Drs. Griffith, Wise, Crone, Norris, Gandhi, Puri, Dong, and all the current PM fellows. Special thanks to Dr. Julia Frank for providing her expertise in discussion of our most recent case of management of opioid use during pregnancy. We look forward to seeing you at the next PMIG meeting.





## UPDATES FROM INOVA FAIRFAX HOSPITAL

### Dr. Cathy Crone



#### **New Faculty:**

Dr. Yu Dong is the new assistant director of the Psychiatry Consult Service at Inova Fairfax Hospital, and she is also

the new Psychiatry Clerkship Director for the VCU School of Medicine / Inova Campus. Many of you are already familiar with her and have worked with her when she was a GWU Psychosomatic Medicine Fellow last year. She completed medical school at the Tianjin University School of Medicine, a Ph.D. in Neurosciences at the Medical College of Ohio, and then her psychia-

try residency at Baystate Medical Center/ Tufts University School of Medicine in Massachusetts. She presented at the Academy of Psychosomatic Medicine (APM) and the APA Annual meetings last year. Her particular interests include psychopharmacology, psycho-oncology, HIV infection and neurocognitive impairment, and neurological disorders with psychiatric comorbidities, though she is also skilled in incorporating the psychodynamic issues into the care and teaching about patients seen on the Consult Service.

#### **New Fellows:**

Dr. Chandrika Balgobin hails from New York City. She attended a B.S./D.O.

program at New York Institute of Technology and New York College of Osteopathic Medicine. She completed psychiatry residency at the University of Buffalo, where she held various leadership positions, including serving as Chief Resident in her final year. Throughout residency, she was involved in a Medical Educator Track. She is an inductee the Gold Humanism Honor Society. Dr. Balgobin's interests include evidence based practice, women's health, and medical education.

Dr. Rachel Goldberg grew up in Indianapolis, IN, and attended Cornell

*(Continued on page 7.)*

## UPDATES FROM CHILDREN'S NATIONAL MEDICAL CENTER

### Dr. Martine Solages



The Division of Child Psychiatry at Children's National Health System has embarked upon a number of exciting initiatives to extend our reach to underserved communities

in the area. We are collaborating with the Goldberg Center for Community Pediatric Health and THEARC (Town Hall Education and Recreation Center) to provide integrated mental health services to several primary care clinics. In addition, Children's National and Georgetown are teaming up to launch the DC MAP program, a mental health consultation service for primary care providers. The program will allow primary care providers to access same-

day input from a mental health team that consists of a case manager, social worker, and psychiatrist. The mental health team will help primary care providers identify appropriate resources in the community, assist with management of common behavioral health concerns, and offer in-person second opinion assessments for children when needed. The Division will also soon provide psychiatric services for children on Maryland's Eastern Shore through a new tele-mental health program based at eninsula Regional Medical Center.

We are pleased to announce that several new faculty members have joined our division's efforts to provide a full complement of mental health services to children and adolescents. Dr.

Katherine Hobbs Knutson, a former Kraft Center for Community Health Fellow, has deep experience in community psychiatry and systems of care. She will be providing co-located mental health services in the pediatric primary care clinics and working with the DC MAP Program. Dr. Finza Latif is now the Director of Psychiatric Consultation and Emergency Department Services. She has particular expertise in pediatric eating disorders and has started an outpatient eating disorders clinic in our division. Dr. Faith Rowland is the new director of the Mood Disorders Clinic and comes to Children's National with a focus on cultural competence in mental health treatment, including a specific interest in the intersection of spirituality and mental health care.



# HOW CAN WE MAXIMIZE THE THERAPEUTIC ALLIANCE IN A SETTING OF RESOURCE SCARCITY?

## Dr. Daniel Lieberman

The most important predictor of the success of psychiatric treatment is the quality of the therapeutic alliance between the patient and clinician. This association between the quality of the alliance and the outcome of treatment is seen in both psychotherapy and medication management. In psychotherapy, developing and maintaining the alliance is often a central goal of treatment, however there is often little time to work on the alliance when a patient and a psychiatrist are pursuing treatment with medication only. Visits are often brief, and there is barely enough time to discuss treatment response, adverse effects, functioning, evolving goals, and treatment options. These discussions in and of themselves can foster an alliance, but it is not their primary purpose. Is there a time and resource efficient way to strengthen the alliance that could be broadly implemented without the need for extensive education and training programs for physicians? In partnership with a researcher in Penrith, Australia, I'm investigating whether the use of an online mood chart can fill this role for doctors treating patients who have bipolar disorder.

A mood chart is a graphical way of tracking the course of bipolar disorder that is designed to provide detailed symptom data to a clinician, and help patients become more ac-

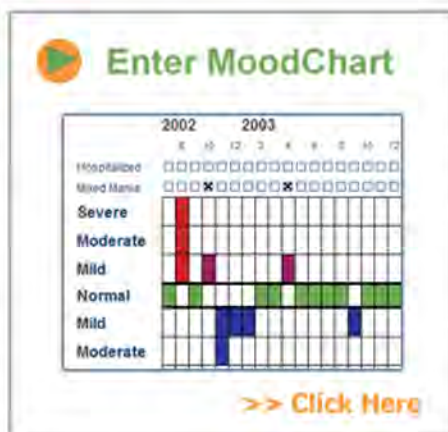
tive participants in their care. It may also help to more closely align the patient's and the therapist's perceived tasks and goals of treatment, thereby strengthening the alliance. The quality of the alliance is being measured using the 12-item Working Alliance Inventory (WAI) developed by Adam

Horvath. Items that may be most sensitive to the use of a mood chart include:

- My doctor and I are working towards mutually agreed upon goals.
- What I am doing in treatment gives me new ways of looking at my problem.
- We have established a good understanding of the kind of changes that would be good for me.
- I believe the way we are working with my problem is correct.

Participants complete the WAI at baseline, and at 3 and 6 months after starting to use the mood charting program. We are also

collecting demographic information in order to evaluate possible moderators of response such as gender, educational level, and length of time in treatment. Currently we're working on an interim analysis of the first 100 participants. If any residents are interested in participating in this research, I'd be happy to discuss opportunities.



## UPDATES FROM FAIRFAX HOSPITAL

(Continued from page 6.)

University, majoring in Psychology. Prior to moving to Northern Virginia, she lived in Atlanta, GA, for 9 years where she completed her MD/MPH and general psychiatry residency at Emory University. As a PGY-4, she was Chief Resident for the outpatient psychotherapy and psychopharmacology clinic at Emory Clinic. She has an interest in healthcare systems, quality improvement, and patient safety. Dr. Goldberg recently attended the APM meeting and is excited about using the electronic medical record for proactive psychiatric

consultation.

Dr. Vanessa Torres Llenza is originally from the beautiful island of Puerto Rico. After finishing college at the University of Puerto Rico and medical school at the Universidad Central del Caribe, she pursued her psychiatry residency at Boston University Medical Center where she served as an advocate for minority recruitment at the medical center and was active in the Massachusetts Psychiatry Society. She is currently a second year APA/MFP SAMSHA fellow and is also a member of the APA Council of Psychosomatic Medicine. Her interests include global/immigrant mental health, increasing cultural competence, and working with minority populations.



# ON-CALL IN THE WINTER

Dr. Jason Emejuru

**On a crisp winter's night**, I entered the hospital assuming it would be an ordinary Thursday on-call night. This is usually somewhat of an unsaid pleasure for residents, since being post-call the following day would give me the "holy trinity"/quasi-three day weekend. I entered the call room, acquired the sign-out list from the daytime residents, and relieved them of their duties. I said to myself: "Let's go."

Being on call at George Washington usually means taking on average 7-8 phone calls from the Emergency Department (ED) over the course of the night and roughly 10-20 calls from the spirited floor nurses on the psychiatric ward. Thus, the resident has to review the patient list swiftly and quickly recognize who are the agitated patients, who are self-harm risk, which patients need to be put to sleep (i.e., who needs Trazodone), and, most importantly (!), who is running the grill down in the café and can whip up a combination of curly fries and sushi - an unpretentious, surprisingly delicious, and efficient combination. Take note, D.C. foodies!

After coming back up to the call room, I received what I thought was going to be a typical call from the ED. I picked up the phone and the emergency room resident tells me: "There is a 23 year old African-American male patient brought in by his family who says that he is hearing voices right now that are distressing to him. He is also slightly fatigued." Before going down to see him, I looked him up on our EMR system and learned that he was admitted to our unit one time earlier in the winter. It appeared to be his first ever admission due to a new onset of schizo-

phrenia. From the discharge summary, he was reluctant to be admitted earlier in the winter and was difficult to engage in the milieu on our unit during his first admission.

As I approached him in the ED, he was laying outside in one of the ED triage beds, which are specifically designated for psychiatric patients. He appeared tired, made little eye contact, but was able to state that "These voices are just too much." I asked him what they were saying and he replied, "Just awful things about me." He then asked, "Could I just get a refill of my medications?. That's all I want." When I of-

**"Could I just get a refill  
of my medications?  
That's all I want."**

fered him admission, he flat out refused. Labs and a urine drug screen obtained by the ED came back as negative.

I remembered the ED resident telling me that his family brought him in, so I immediately shifted my focus toward them. His grandmother and his uncle, a DC police officer, were sitting in the visitors' section of the department. After pulling them to the side, the grandmother told me how she has taken care of him since he was a child. "His mother has her own issues," she said. She told me how difficult it had been since he was diagnosed with schizophrenia a few months ago. He had not been compliant with his psychiatric appointments or his medications since discharge. He had been admitted to

another psychiatric unit in the city a few weeks after his discharge from GW. She told me that the family is "terrified" of him because he had been getting violent at home. He was three weeks removed from swinging a baseball bat at his 17 year old brother after believing that his younger brother had placed a microchip in his head to "steal his thoughts." His grandmother and his uncle made a preemptive decision tonight to take him to the hospital for admission before things escalated in their home.

The uncle was adamant that "he can't live in this house if he is going to continue not to take his medications and be a danger to everyone." I could tell, however, that there was some reluctance in his voice. As I realized that there may not have been enough evidence to involuntarily commit him, I asked his grandmother and uncle if they were prepared to let him sleep on the street tonight? This was after telling them that we may not be able to involuntarily commit him. Their expressions soon changed the room's atmosphere to one filled with sorrow and uncertainty.

During this time, I noticed that I had become somber also. I, too, had a dear college roommate who had his own first episode of psychosis, but who fortunately experienced his own less-traveled road to recovery. Recognizing this, I consulted with the ED attending, who encouraged me to try for an involuntary commitment. I imagined that he would only have a short stay since the justification for commitment was a bit thin. But at least he would get one or

*(Continued on page 9.)*



# THE GREATEST LOVE OF ALL

Dr. Karen Wooten

**I wasn't exactly looking forward** to remediating a month of Internal Medicine at the beginning of my PGY2 year. Obviously, it hadn't gone so well the first go around. At least now I knew how to work the computer software!

Fortunately, I started with a fantastic team led by a self-deprecating senior resident. The first day when we were running the list he said, "This is a 23 year old girl with a history of severe autism and esophageal candidiasis who presents with failure to thrive. (Long pause) I haven't got a clue what is going on with her. (Longer pause) Can you please work some of your psychiatry voodoo magic so I don't have to send her home with a G-tube?!"

I told him "Probably not," but secretly I appreciated the challenge and longed to be the unlikely hero.

The patient could walk to the bathroom with help, but she mostly just laid in bed staring blankly at the TV or window. She had lost 16 kg from not eating for two months and would sometimes grimace and point to her stomach. My well-honed interviewing skills were useless as communication was limited to occasional groans or one word whispers to her mother.

Her mother, who was almost always at bedside, said she had been able to dress and feed herself up until she moved to the US from Eastern Europe four months earlier. Psych consult had already seen her and hypothesized that maybe she was depressed or demoralized. Thus far, PO Mirtazapine hadn't worked any miracles. Shocker.

I read in her chart that she had previously been involved in music classes. Her mom said that she loved Whitney Houston and knew every lyric of all her songs. Fantasizing that my voice could break her spell, like in a Disney cartoon or something, I tried singing a Karaoke favorite, "Greatest Love of All." Nothing. She just stared. Glad I didn't quit my day job.

But there was something in the way she held her arm one day that reminded me of an old lady I had as a patient on the psych unit at Fairfax. They both looked like they could be mannequins in a museum exhibit entitled "Human Fear." It was as if their brains were so occupied with anxiety that there was no mental power left to operate their bodies. I had the feeling I could just move their limbs all around like gigantic catatonic figurines.

I convinced my attending that Lorazepam challenge was a high-benefit, low-risk treatment. I think I may have used the technical phrase, "It's worth a try, right?"

So I was so disappointed when I rounded the next morning to find her status completely unchanged. Then I found out that the nurses had held the Ativan due to "not appropriate: patient sleeping." I rewrote the orders and educated the nurses about catatonia. I also scheduled the challenge for a time when the patient's mother would be there to detect any slight changes.

As I returned to the room, I heard laughing. My patient's mother was laughing and crying. Her daughter was talking, moving, and basically coming back to life! As I walked in the door, the patient started to sing "Greatest Love of All." Seriously. It was like I had my Disney movie. That

night she was eating her favorite food – spaghetti.

Meanwhile, I was at the dinner table telling my family about "Maybe the best day EVER." Even now that I am on the safe side of Step 3 with my Medicine days behind me, I am so grateful that I remediated medicine. I am so grateful that God put me in the perfect place, with the perfect knowledge, at the perfect time to work His miracle.

***"Can you please work  
some of your psychiatry  
voodoo magic?"***

## ON-CALL

*(Continued from page 8.)*

two days of necessary treatment, the family could get some peace of mind knowing he would not be on the street, and they could prepare for him returning to their home.

I went upstairs to the call room and wrote the involuntary commitment letter with which his family was in agreement. I have since wondered, "Where is he now?" Did this likely brief commitment help or did it make his situation worse? How does he now perceive the health care system (as represented by me) and his family that supported my decision?

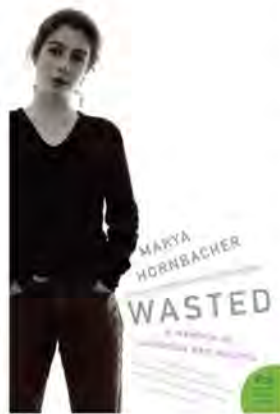
*Reprinted, with permission, from the Washington Psychiatric Society's winter 2015 issue of "Washington Psychiatrist."*



## BOOK REVIEW

### Dr. Stefani Reinold

**As I first began my rotation** on the Adolescent Psychiatric Unit, I felt out of my element. My first patient was a 16 year-old male with a history of obesity and associated bullying for being the "fat kid." He lost almost 100 lbs in the past year, but now struggles with a daily mind reel of fears, worries, obsessions, and body image woes that manifest into binges, purges, and an overall distorted relationship with food. I am taken aback. I feel at a loss for what I can do for him. I feel his pain when I talk with him, but why do I also feel the desire to both commend him on his weight loss and also shove food down his throat at the same time? How will I ever help him? From this encounter, I craved more knowledge concerning eating disorders. Listed by many experts as an "eloquently written" and "hallmark" case study, *Wasted: A Memoir of Anorexia and Bulimia* by Marya Hornbacher won the bid for my attention. Through beautiful and hauntingly descriptive literary prose,



Hornbacher takes readers into the internal struggles of her own personal experience as a bulimic turned anorectic. Her story reads like a novel; it's hard to believe that everything is happening to a real person. To my surprise, Hornbacher does not have the horrific trauma history that I have been taught to expect. She has close friends, many talents, and has been supported in her life. However, her support system is fractured in its own respect, and the message that I was able to take away was that trauma can come in all shapes and sizes and likewise, eating disorders can afflict anyone. Unfortunately, Hornbacher does not offer much psychoeducation about the treatment of eating disorders that I was craving. In fact, Hornbacher makes many negative comments towards her own psychiatric care; these digs made me feel defensive, but also a little inadequate to come to the defense of eating disorder treatments. And also disappointingly, although true for many patients with an eating disorder, there is no joyous conclusion after 320 pages. If your goal is to be sucked into the disturbing reality known as the eating disorder-plagued mind with a seductive twist, then this book will help you to appreciate eating disorder patients in a whole new light. If a happy ending is your wish though, then *Wasted* would not be my recommendation.

## RESIDENT PUBLICATIONS & PRESENTATIONS 2013-2014

**Bhatty, S & Sloatsky, V.** (2014) "A Cognitive Behavioral, Brief Therapy Model for Cancer Survivorship." Poster presented at American Psychiatric Association, May 3 2014, Washington, DC

**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

**Khin Khin, E, Minor, D, Holloway, A, Pelleg, A.** (2014) Decisional capacity issues in amyotrophic lateral sclerosis. Poster presented at the American Academy of Psychiatry & the Law Annual Conference in Chicago, IL.

**Khin Khin, E, Minor, D, Pelleg, A.** (2014) Stealth assassins: Professional serial killers. Poster presented at the American Academy of Psychiatry & the Law Annual Conference in Chicago, IL.

**Minor, D, Khin Khin, E, Jones, T, Garibay, D.** (2014) Institutional liability in college suicides. Panel presentation at the American Academy of Psychiatry & the Law Annual Conference in Chicago, IL.

**Pascoe A, D'Silva S.** (2014) The twilight years: Wisdom teachings and transgenerational growth. Poster presented at the Society for Humanistic Psychology (Division 32), American Psychological Association. Annual Meeting. Palo Alto, CA.

**Sloatsky, V, et al.** (2014) "The Development of a Global Mental Health Caucus in the American Psychiatric Association." Poster presented at American Psychiatric Association in New York, NY.

**Sloatsky, V.** (2014) Dealing with uncertainty in genetic testing. *Psychiatric Annals*, 44(7): 329-333.

**Vyas, R, Khin Khin, E, Minor, D.** (2014) Kapow: When psychiatry and the world of comics collide. Poster presented at the American Academy of Psychiatry & the Law Annual Conference in Chicago, IL.



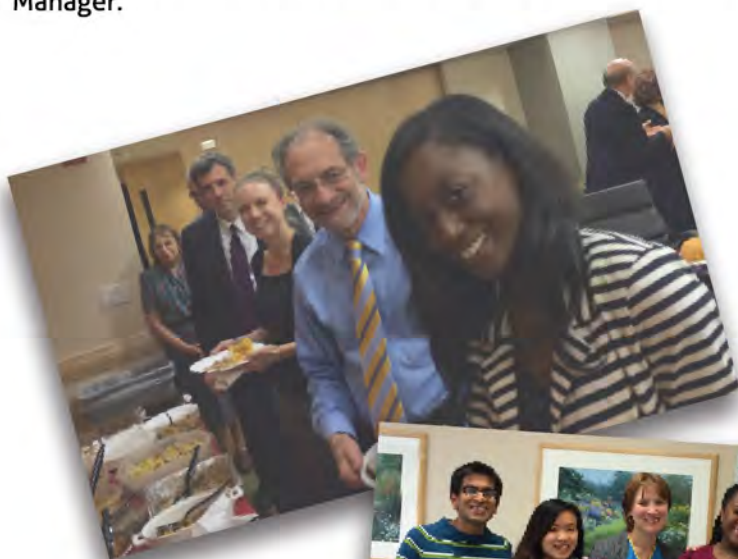
## KUDOS & CONGRATS!

**Dr. Michael Morse**, PGY 4, on being awarded the Laughlin Fellowship.

**Dr. Sally He**, PGY 2, on winning the September Case of the Month.

**Dr. Baiju Gandhi**, who is the new C/L attending in the hospital.

**Mr. Trevor Forde**, who has been promoted to Department Manager.



## WELCOME & GOODBYE!

**Ms. Victoria Anderson**, who is the new residency program coordinator.

**Mr. Evan Workman**, who is Dr. Griffith's new executive coordinator.

**Dr. Sabine Cornelius**, who is a new therapist in the outpatient practice.

**Dr. Lori Kels**, last year's Chief Resident, who has joined the outpatient practice as a new psychiatrist.

**Dr. Rashelle Browne**, who will be leaving GW at the end of the year.



***Thank you, writers and readers!***

Content : Karen Wooten | Copy Editor: Elizabeth Greene | Layout: Shuo (Sally) He  
Contributor: Victoria Anderson | Advisor: Dr. Eindra Khin Khin