Intensive Supervision

When I was a psychiatry resident, the program offered at Columbia was probably one of the finest in the nation. I think it still is. We had unparalleled exposure to patients, wonderful lectures and seminars. But the backbone of any psychiatry program is individual supervision, where the full-time staff, augmented by many senior volunteers, provide one-on-one training. Evaluations of new patients, with elaborate case write-ups, are supervised, criticized, and redone until they sparkle. Short-term patients and pharmacology patients are reviewed, and the resident learns, case by case, how to provide the highest quality care.

For me, with my eyes already on psychoanalytical training, the supervision of long-term patients was the most cherished. I would see a patient twice a week and sit at the feet of a master once a week to review process notes of the sessions, as close to stenographic as possible. The resident-supervisor relationship was often mutually enriching and cordial.

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As my last year of residency was coming to a close, I began to discharge or transfer patients to prepare for my 2 years away in the Army. At the end, I actually had more supervisors than patients. Such a luxury! Such a comfort! I had not yet taken on the awesome and terrible responsibility of treating a patient *alone*, that is, without the protective embrace of my institution.

When I arrived at Fort Custer, Colorado, I quickly realized that there was no one around to advise me. Major Nathan Bedford Forrest, a career military social worker, knew everything about the Army and its workings. He was extraordinarily helpful in knowing the resources available and how to pull the right strings to get them for our patients, but no one at Fort Custer knew more psychiatry than I did. Also, quite beyond the practical needs in carrying out my daily tasks, I missed the rich intellectual exchange with supervisors that I had in residency. I was seeing many interesting patients, some totally different from those I had been used to at a big urban medical center, and I craved an opportunity for a master's expertise and wisdom.

So it was with some excitement that I put in a call to the Fifth Army Psychiatrist at George Armstrong Custer Army Hospital 2 hours away in Pueblo, Colorado. I introduced myself and asked about the possibility of driving down to see him for some supervision on three complex patients. "Yes, Druss, that will be fine," said Lt. Col. Warren, "I'll have my car waiting for you at 0700 hours on Monday."

I spent the weekend writing and rewriting my three case histories with a care I had not given since my residency ended 4 months before. My driver, Corporal Nym, arrived promptly at 7:00 a.m. If it is possible to sit at attention without moving one's head a millimeter, uttering not a single word other than "yes, sir," and "no, sir" for 2 hours straight, Corporal Nym could do it. He drove me silently and swiftly to Fort Custer, and I was in Colonel Warren's large office at 9:00 a.m. The Colonel was seated with a glass of bourbon and ice in hand, stirring it with his right index finger. "What are you drinking, Druss?," he asked cheerfully.

"I'm fine now, Sir," I responded.

"Let's begin," he said, taking up a note pad. He could not have been nicer and more welcoming.

The first patient I presented was Private Peto. He was self-referred because of a compulsion to dress in women's clothes and walk around the post risking arrest. His father had been sent to prison when the patient was under a year old. He was raised by his mother, older sister, and grandmother. I asked Colonel Warren if this could be an identification with all the powerful women in his family. Was this just an odd form of risk-taking behavior with an unconscious wish to get caught and jailed? Or, was this a young man who was malingering and wished to get out of the Army *a la* Corporal Klinger in the *M.A.S.H.* television series? Saying nothing specific, Colonel Warren took a few notes and told me to go on.

The second patient was Major Bardolf, an infantry battalion commander. He had been referred by the medical people at Fort Custer because he had the delusion that he had neurosyphilis. He had been spending hours in his unlit bathroom, standing before the mirror with a flashlight trying to see if he had Argyll-Robertson pupils. (An Argyll-Robertson pupil is one that narrows as the eyes get closer to an object, but does not respond to light.) Did his pupils react to light? He was testing them again and again with the flashlight. Tertiary syphilis had been ruled out serologically many times, but Major Bardolf remained unconvinced. I told Colonel Warren that he denied having hallucinations. Quite beyond the psychopathology, I asked why he had picked an exotic and rare sign rather than the more usual concerns about his genitals or other organ systems. Did this reveal an oedipal issue and, like Oedipus, was he attacking his own eyes as self-punishment for incest? What were the patient's primary defense mechanisms other than somatization? Colonel Warren took more notes.

I presented my third and final case, which I can now no longer remember. Finally, Colonel Warren cleared his throat and spoke:

"The first man goes out under AR-635-89 and the second two under AR-635-209."

He put down his glass and rubbed his hands together.

"Now, Druss. Let me show you our golf course."

On the 2-hour trip back up to Fort Custer, Corporal Nym at the helm, I realized that I was, finally, at long last, for better or for worse, completely on my own.

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All names and places have been disguised.