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This Issue

Introduction

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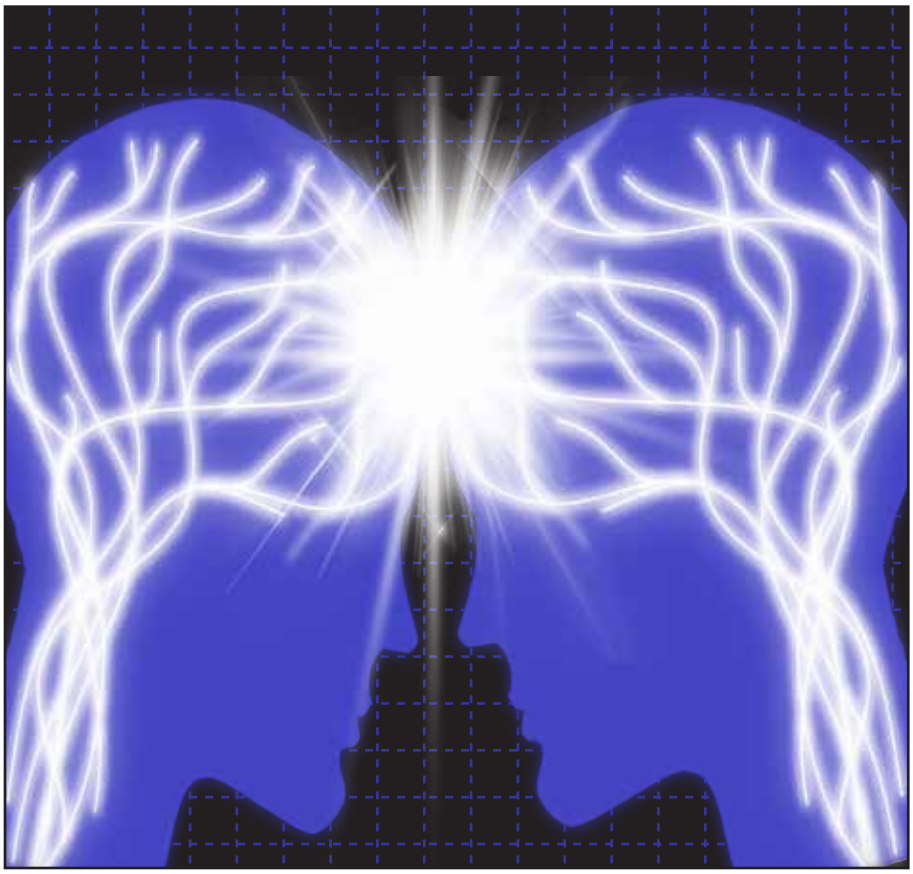

This month's issue of the Residents' Journal emphasizes relationships in residency. In this issue, five articles, as well as one interview, provide different perspectives on the relationships we experience as residents: relationships with our patients, the countertransference they elicit in us, and the inherent dichotomy of perspectives between healthcare provider and the patient with psychosis; relationships with industry and the financial pressures our patients encounter obtaining healthcare; and, last, relationships with ourselves through mindful awareness in the practice of psychiatry. The objective of this issue is to promote reflection on the ways in which we engage and interact as psychiatrists so that we may be deliberate in our dealings with others. I have found the following quote by the philosopher Philo of Alexandria, shared with me by a senior member of my faculty, very useful during my training: "Be kind, for everyone you meet is fighting a great battle."

A Conversation With Frances Koenig

The following is a conversation with Frances Koenig, Ph.D. on "Countertransference." Dr. Koenig received her Bachelor's degree in philosophy from the University of Houston after attending both Stanford and Rice Universities. She earned a Doctorate degree in Psychology in the Counseling Psychology Program at the University of New Mexico, Albuquerque. She has been an Adjunct Professor in the Departments of Psychology and Psychiatry at the University of New Mexico, Albuquerque, and has chaired the Board of Psychologist Examiners of the State of New Mexico. Dr. Koenig continues to be an active supervisor of psychology graduate students as well as psychiatry residents and presently divides her time between a thriving psychotherapy practice and her family ranch in Northern New Mexico. Dr. Young is a third-year psychiatry resident at the University of New Mexico, Albuquerque, and will be entering the Child and Adolescent Psychiatry Fellowship at the University of California, San Diego in July 2009. Dr. Young is also this month's Issue Editor.

Dr. Young: While considering what discussion might be of use to incoming residents in psychiatry, I thought of countertransference in particular. I remember the intensity of feelings I had toward certain patients early in my training, particularly those with axis II pathology. I was surprised by the aversion and, at times, even outright malice they elicited in me—not to harm overtly, but in a sense to "get back at them" for what I now interpret as being made (so I thought) to feel incompetent and insecure. This frightened me because one enters medicine, and psychiatry in particular, to understand and help others. Initially this was disconcerting, until I discovered a whole body of literature exists on the subject. I learned ambivalence is not indifference but rather the simultaneous experience of two opposing feelings. It is possible to care deeply about your patients and, frankly, to experience hatred toward them at the very same moment. It has been comforting to learn, through the literature and deliberate discussion of the idea in residency didactics, that this is a natural part of being a therapist and psychiatrist. The key seems to be adequate awareness and processing of these countertransferential feelings. How have you approached this issue, both early in your career and today?

Dr. Koenig: It is very important to maintain an awareness of these internal experiences. During my training, it was not a demand of the program that one be analyzed in order to practice, but at the time I felt it would be very important. There was a psychoanalyst in Santa Fe, where I was living at the time, who still provided the old-fashioned psychoanalytic experience, where he sat behind the couch. You never saw the expressions on his face, and he was basically passive and silent throughout most of the therapeutic encounter. We did a lot of dream work, which I found very interesting, but it made me recognize at the time that it was not the way I wanted to practice therapy. I felt one could use oneself in a more creative, compassionate, effective, and efficient manner than he used himself. In fact, I think at times he was asleep.

Regarding what you said about negative feelings, I have found that if they persist I don't generally continue to work with the person because it can be hurtful, both to me as a therapist and to the person with whom I am trying to work. A lot of the

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In addition to this online edition of the Resident's Journal, there is an e-mail portion delivered each month. This month's e-mail highlights identification of a schizophrenia-associated variant in the NOS1AP gene and predictors of spontaneous and systematically assessed suicidal adverse events.

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therapeutic relationship depends upon a certain sort of chemistry and fit to support the therapeutic gains of the person you are seeing. If it's not there, I think it's impractical to try and make it fit better. The therapeutic relationship needs to be one in which I make myself as available as I can possibly be to the process. If I am antagonistic and unhappy in the relationship that I am experiencing, I will be less effective. I don't work with people that I have very strong negative responses to. I refer them out.

Dr. Young: Despite this, I also know you have the capacity to deliberately put yourself in a place where you can understand a person's suffering. I suspect you have worked with patients who have a history of intensely negative affect and, at times, destructive behaviors, and I sense you have a high capacity to tolerate that. Do you think the frequency and intensity with which you experience countertransference toward difficult patients has changed over the course of your practice?

Dr. Koenig: The few patients over the years that I have been ineffective with are those who are unwilling to be responsive to any input that I offer to help create change in their lives and who respond with either "Yes, but…" or fail to follow through on homework or change outside of the therapy sessions. In these instances, feelings of frustration and impotency are nearly constant feeling states in me, and rather than vent my anger and frustration on them, I will refer them out. Perhaps that is countertransference, or perhaps that is a practical recognition that I can use myself much more effectively with another patient at another time.

Dr. Young: Some might say when we experience intense feelings toward another, it's a reflection of something in us, so we should stop and look for it because we can learn much about ourselves. It raises the question, do patients who bring a specific defense mechanism, coping style, or personality that reflects one's own as a therapist generate a particularly intense countertransference in the therapist? For example, do you think the narcissistic therapist struggles most with narcissism? Or, do you think some particular use can be made of similarities?

Dr. Koenig: If the therapist is extremely narcissistic, I have real concerns about how effective he or she will be in a therapeutic setting. This is because his or her needs are going to overwhelm the relationship in a way that is potentially going to be hurtful and ineffective. I'm one of these people that feel a therapist must be healthy in order to be effective because the material that is brought in to you—the pain, the confusion, the loss—weighs heavily upon you. To be effective as a therapist, one needs enough sturdi-

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ness and stability in terms of one's own ego development. I am very impatient with therapists who use the therapeutic relationship for their own growth. It is unacceptable.

Dr. Young: It seems that, historically, the goal of the neutral analyst was to be perfectly analyzed through resolution of one's intrapsychic conflict in order to be capable of analyzing another. While I suspect their intentions were good, perhaps to develop the sturdiness you mentioned, neutrality seems artificial and almost deliberately devoid of humanity. What you have described is, I think, a much more reasonable effort to connect in a human way while being realistic about one's own limitations as a therapist.

Dr. Koenig: Early in the history of psychoanalysis, relationships extended over years of therapy. As therapists today, we don't have that luxury. When an insurance company mandates you to treat a major depression in six sessions, you're not going to do it by having a neutral countenance. You have to use yourself differently, and you have to move the nature of that partnership in a much more forceful fashion than when one had the luxury, and I think also wastefulness, of unrestricted time. The notion of being a blank screen is no longer efficient or economically feasible, if it ever was. Therapy demands an interactive relatedness.

Dr. Young: I have noticed some patients will bring to therapy a clear sense of anger in their experiences, but it seems anger can, at times, be displaced defensively into other mood states and emotions. In these situations, I find paying close attention to the feelings elicited in me helps get to the root of what troubles them. What do you find patients elicit in you that makes you say, "Ah, there's anger or a threatened state underlying this?"

Dr. Koenig: First, what you need to do as a therapist is help the individual come to recognize what it is they are feeling because, frequently, when people enter into therapy, they have a wealth of sensations that are very confusing. I approach this by listening empathetically and reflecting back to get as much information and clarity as I can.

Anger can be a response to a frustrated goal, as in missing an appointment because of car trouble, or, more importantly, it can be a defensive response to feelings of loss of control or threat to self-esteem. Helping a patient understand the emotion, its etiology, and potential is very important. When a patient realizes that the inchoate feeling of anger can be understood and that understanding can be used to reach a goal in a relationship with another, the tyranny of emotional passivity is challenged. This is often the beginning of change and growth in the therapeutic alliance. This process of change demands active intervention on the part of the therapist and trust and credulity on the part of the patient.

Dr. Young: Residents become quite familiar with the countertransference of suicidality. This may be a product of the number and variety of clinical settings in which we work—from psychiatric emergency services and inpatient units to clinics and psychotherapy rooms—but whether suicide is truly preventable by us is a question I am far from answering. Much of the countertransference literature addresses suicidality in particular, probably because it is such an intense experience to carry the idea that your patient's illness might lead to their death in a lonely, potentially hideous way. When patients come to you feeling so hopeless and overwhelmed that they are suicidal, what do you experience?

Dr. Koenig: Fear, pain, and impotence. When your patient is suffering from seemingly unremitting despondency, the feelings of impotency are unmistakable in both you and the patient. With that impotency comes a fear that the feeling state of depression will ultimately overwhelm both you and your patient. In the meantime, you dredge up as much energy and practicality as you can manage to hold them to the belief that change may be forthcoming and the unremitting pain may lift. Your perspective must encompass every moment of pleasure they have shared with you and every modicum of hope you and that patient have held together.

Dr. Young: How do you manage your fear?

Dr. Koenig: It's ongoing and constant. You use yourself as effectively as you can to give that person something beyond the anguish that they are feeling in the moment.

Dr. Young: Involuntary hospitalization of patients to prevent their suicide has been confusing to me. In particular, suicide while hospitalized seems incredibly traumatic—to the patient, their families, and the hospital staff. It is very difficult to reconcile this experience when patients seem absolutely determined to end their lives no matter how much is done physically, structurally, and environmentally in the hospital. I have noticed this fear informs the countertransference I experience with suicidal patients.

Dr. Koenig: The reality is that suicides occur frequently after hospitalization for suicide intent. When you and your patient know that the future they face offers no release from pain and suffering, then to hold them to an empty promise of relief is questionable at best. To take from them their right to assert control over their suffering is a question we as mental health professionals need to tackle more honestly and actively.

Countertransference: A Primer for Residents

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Past experience influences all interpersonal interactions. Yet, within the context of our work with patients, as psychiatrists we must maintain a particular awareness of how exchanges are informed by previous relationships to ensure a positive therapeutic experience for our patients. The term "countertransference" describes our internal reaction to patients, and it mirrors the internal experience patients elicit in others. We should use this understanding of how patients relate to the people in their lives to help us navigate our interactions with them in a positive way and to help them increase their capacity to forge healthy and nourishing relationships. This endeavor dominates the development of psychiatrists-in-training and challenges us to remain energetic and deliberate in our encounters.

Decades ago, Engel (1) proposed a biopsychosocial model, which describes the need for physicians to embrace a comprehensive model of care that addresses not just the biological but also the psychological and social contexts in which illness occurs. Over the years the discipline of psychiatry has, to varying degrees, accepted and integrated its approach to these three interrelated spheres within which illness manifests. Today we have the opportunity to understand each of these elements with a high degree of sophistication, and with each patient, we should approach his or her treatment by integrating our findings. Stated differently, complex pharmacotherapeutic regimens appear helpful until we recognize that patients may lack the financial and social support to afford, obtain, or adhere to these regimens (2). This same biopsychosocial approach can be useful when thinking about countertransference and the way it affects our diagnosis and treatment choices for our patients.

What sets psychiatrists apart from other medical professionals is that we treat symptoms of the mind. Mental disorders are diagnosed clinically, with very few objective studies available to us to confirm diagnostic accuracy. We assess the interplay among emotions, relationships, and life histories and try our best to integrate them in our approach to treatment. Still, the complexity of symptom dimensions, the obscurity of their etiology, and the poorly understood mechanisms of our treatments typically create ambiguity. This is what makes psychiatry perhaps the hardest specialty to practice, but it is also what makes it so rewarding (3). These ambiguities also make an understanding and appreciation of our reactions to patients (i.e., our countertransference) all the more important.

The same biopsychosocial obstacles that beset our patients can frustrate us as their clinicians. Frequently, patients have developed intricate layers of defenses to protect themselves from the weight of these challenges. When a psychiatrist steps into the mix and proposes changes, it may induce fear and anxiety in patients who have at least managed to maintain their lives by employing these defenses. Understandably, we upset the balance by suggesting that patients abandon maladaptive coping mechanisms, such as avoidance, narcissism, substance abuse, self-injury, and suicidality, in favor of openness to growth and change. In acutely anxious and tense settings, such as the psychiatric emergency room, a patient may react with incredible intensity toward us: "You don't know anything about me! I'm not your guinea pig! I hate you! I'm going to kill you!" In psychotherapeutic settings, this process is likely more subtle, but the exchange can still be palpably disconcerting.

Not surprisingly, the experience of this transference is unsettling to one who has invested so much to become a physician and psychiatrist. We likely do not expect such intense resistance to our arguably altruistic attempts to encourage a troubled individual to consider the possibility that their defensive structures are detrimental. Countertransference may arise in us as we react from the perspective of our own defenses and insecurities. The less experience one has with this, the more likely one is to react with aversion: "Get this patient out of here" or "Get me out of here." Worse still, this experience may manifest as malice—the actual desire to do harm (4). Due to the generally well-nourished superego of the physician, this malice typically manifests not through reactionary urges of physical violence but rather through, perhaps, a judgmental stance (e.g., feeling that a patient is hopeless) or punitive use of authority (e.g., involuntary hospitalization) to "teach a lesson." Some patients seem to have developed an expertise at generating these feelings in us, leading to the countertransference mantra: "If a patient gets under your skin, consider the presence of axis II pathology" (5).

It is essential that we do not allow countertransference feelings to manifest as avoidant or malicious behaviors. Ignoring these feelings when we experience them furthermore generates the risk that they may subconsciously result in detriment to the patient (4–6). The trick is to maintain awareness of these feelings and to carefully manage them.

An early step in this process is to recognize that as psychiatry residents, we are often gatekeepers to social services: clean sheets on a soft bed in a heated facility; food; medications and medical care; a staff of supportive listeners; the chance to abstain from substances of abuse; safety from violence and exploitation; links to discharge disposition, including housing, employment, and outpatient services; and so on. Patients may use stunning manipulation to pursue these needs, but we should remember that they are often in crisis, burdened with anxieties we can hardly imagine, and thus consequently incapable of experiencing gratitude. If we react to our frustrations and insecurities by becoming miserly and restrictive, we are in essence focusing on our own perceived needs while forgetting the person

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directly in front of us is just that—a person—or rather that he or she is not just an object and obstacle to an hour of sleep, the approval of a supervisor, or another lawsuit-free year. Not all patients will present with insight and motivation to change, but all patients deserve the opportunity and encouragement to develop these attributes (7).

Nearly every patient we see will elicit feelings in us, whether these feelings are calm assuredness at a simple solution proposed, such as directions to the pharmacy, or sheer horror that a patient might kill him- or herself or someone else if discharged from the emergency room. When we feel something strongly in the process of caring for our patients, we should remember to listen carefully to that feeling and to strive to remove our own needs from the equation. It is important that we understand that tensions in interactions may escalate as people engage competitively, coming to view each other as objects rather than individuals. We must challenge this process by being as empathic as possible.

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Mindfulness: A Framework for Integrating Tradition With Evidence-Based Psychiatric Practice

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The practice of mindfulness springs from a living tradition 25 centuries old. In one of its contemporary psychological iterations, mindfulness has been described as "paying attention, on purpose, in the present moment, non-judgmentally" (1). Classical treatises have outlined a multitude of subjective and objective effects of mindfulness (2, 3). Recently, neuroscientists have taken increasing interest in the neurobiology of mindfulness and associated practices, aided by collaboration with experienced meditative practitioners (4, 5). Moreover, clinical research on mindfulness-based practices continues to proliferate, and the therapeutic implications appear promising (6).

In the present article, I wish to briefly share a clarifying perspective about mindfulness, outline some of its classically noted effects, and, drawing on traditional writings, highlight some testable hypotheses about mindfulness in psychiatric practice, some of which have not been fully explored.

In a fundamental sense, mindfulness is nothing special. It encourages recognition of and reconciliation with the richness of ordinary daily life. Many people embody mindfulness quite naturally without reference to words or concepts. It can arise spontaneously, although practice helps. Furthermore, practicing mindfulness does not depend on the beliefs of the practitioner. In its essence, the practice of mindfulness is simple, straightforward, and secular, although not always easy (7).

The most basic practice of mindfulness entails focusing attention on breathing—in and out (8). Traditional literature tells us that, when repeated, this simple practice can quiet the mind and body, build capacity for sustained concentration, and permit clear observation. It allows insight into constructive and destructive habits of thought, speech, and action and supports informed behavior choices (9, 10).

Based on personal experience, a basic acquaintance with the traditional literature, and some familiarity with the scientific evidence, I propose that mindfulness has three valuable and testable roles in the psychiatric setting. First, as a personal practice, mindfulness may provide the clinician with a method to calm, attend to, and investigate his or her own mind and body. Additionally, it allows the therapist to engage his or her patients from a place of increased stillness, circumspection, and compassion. Several authors have explored and tested some of these hypotheses in medical and psychotherapeutic settings (11, 12). Second, as an instructional practice, mindfulness may facilitate teaching the patient to remain calm, attend to, and investigate his or her own mind, body, and surroundings. This may lead to improved insight and judgment, decreased stress, and a therapeutically altered attentional relationship to illness. The literature on mindfulness-based stress reduction and mindfulness-based cognitive therapy has tested some of these hypotheses in a preliminary fashion (13-15). Last, as a group practice, mindfulness may promote a community atmosphere of nonviolence and understanding. I am unaware of published studies investigating this broader, community-based aspect.

Mindfulness has the potential to benefit psychiatry in both theoretical and therapeutic ways. However, medical literature on the subject remains largely nascent. While it is important to construe the study of mindfulness in terms of contemporary psychobiology, a careful investigation of the traditional literature remains crucial for hypothesis building and directing lines of clinical inquiry.

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Residents and the Pharmaceutical Industry

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There has been a recent movement to criticize pharmaceutical companies and to limit the access their representatives have to medical students and residents for a variety of reasons. If these criticisms were limited to the perceived conflict of interest in certain marketing practices, there might be validity to them. Indeed, the pharmaceutical industry has recently revised its marketing code to deal with some of these issues (1). Unfortunately, opponents of pharmaceutical companies rarely stop there. Their criticisms are usually much larger in scope, encompassing "me-too" drugs and often demanding to dictate terms to companies with regard to the medications they develop (2).

I find these developments worrisome. Although the evaluation and scrutiny of pharmaceutical companies and their products is essential to their regulation and to patient safety, some of the justifications given by opponents appear to be based on a poor understanding of the industry.

Consider the travails of the pharmaceutical companies. In order to bring a product to market, potentially thousands of candidate molecules fail before a single one wins approval by the Food and Drug Administration, at the cost of hundreds of millions of dollars due in part to the clinical trials required by regulation (3). Once they are on the market, drugs may still fail. For their considerable investment, companies receive a time-limited monopoly: a patent on their product. Prior to its expiration, they will attempt to recoup the costs of investment in a particular drug and the ones that have failed. It is no surprise they assertively market their products.

Paradoxical as it may seem, the presence of pharmaceutical representatives on medical school campuses is actually evidence of an innovative, competitive marketplace for pharmaceuticals. More concerning would be their absence, as this would demonstrate the lack of a dynamic market. Why is this so important? Opponents of the pharmaceutical industry often cite a "preponderance of me-too drugs," which they claim only offer a marginal benefit over existing drugs. However, I believe we not only require new and better medications, we also require more medications. We have only begun to study pharmacogenomics, and we do not yet have the ability to "gene-chip" our patients to determine the most appropriate agent. Even if that day arrives, I would prefer to have the most options available to me to treat my patients. Furthermore, I have found that the "marginal benefit" offered by "me-too" drugs on a large scale is often a tremendous benefit in safety, tolerability, and efficacy for individual patients.

Another charge by opponents is that residents and medical students are "impressionable trainees," vulnerable to the marketing practices of pharmaceutical companies (4). In light of my on-call responsibilities as well as those of my colleagues, I find this somewhat disingenuous and insulting. At my program, we are the only 24/7 psychiatric service in the state of New Mexico and surrounding rural areas. After all, if I can make critical decisions in the middle of the night as the only psychiatric specialty service available for such a large area, why should I not be able to make decisions regarding the veracity of a drug maker's claims?

The motivations of the pharmaceutical industry are clear. They wish to make money on their investment. Interestingly, the pharmaceutical industry is often accused of earning "excessive profits." This ignores the realities of capitalism. The research and development of new drugs is a capital intensive, highly regulated and risk-filled venture. All these factors make for higher profit margins. Further, it is precisely these profits that are reinvested into new product development. Better still, for both patients and prescribers, the branded multibillion-dollar blockbuster drug of today will likely become the $4.00 generic of tomorrow.

For these reasons, I think it unwise to demonize pharmaceutical companies. Although we need to think critically about their marketing, just as we think critically about our own practices and those of our colleagues, understanding their motivation is key to ensuring that we do not place the interests of others before those of our patients.

Dr. Vlaskovits owns one drug company pen, one mug, two textbooks, and one address book, none of which may be used at his workplace, and he has attended a number of pharmaceutical industry-sponsored lunches and dinners. Dr. Vlaskovits otherwise has no financial interest in pharmaceutical companies.

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When the Money Runs Out: Forced Termination for Financial Reasons

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"She's got a large balance, and she can't make a payment. You'll have to refer her elsewhere," the patient financial counselor said before I greeted my final psychotherapy patient of the day.

As I greeted my patient, I could see her tears. Once in the office, she yelled, "I can't do this!" She then pounded her fist to her head. I sat silently as she continued to cry, desperately searching for a solution to this problem and hoping that I appeared empathetic.

The patient had recently been fired from her job and had sunk into a deep depression. She had neglected her bills and, subsequently, changed her phone number so that collection agencies would not be able to contact her. She was 3 months delinquent on her rent, and the gas and electricity in her home were being turned off. She no longer had health insurance, and even with the hospital's charity care program, she was unable to make payments. Nevertheless, she remained committed to therapy and had faithfully come to sessions for several weeks.

During residency, I terminated psychotherapy because patients refused to follow recommendations or were noncompliant. Patients also terminated with me, often abruptly because they could not make the time commitment or were just not comfortable with me as a therapist. However, I had never encountered this circumstance: a therapist and a patient both motivated for treatment but unable to continue.

In today's economic climate, patients are frequently forced to end treatment for financial reasons. In a recent study investigating patients' reactions to the timing of termination of psychodynamically oriented psychotherapy, financial circumstances were cited as the most common cause for therapy ending "too soon" (1). Managed care companies frequently limit payment for psychotherapy sessions, forcing therapists to terminate therapy prematurely when patients are unable to pay (2).

Literature on forced termination has focused on the experiences of therapists-in-training as they terminate with patients upon completion of training. Baum's survey (3) of social work students revealed feelings of sadness, regret, self-doubt, and anger among students when they were forced to terminate with patients at the end of training. Although the circumstances were different, I experienced all of these emotions as I sat with my patient.

Could I have prevented this unfortunate outcome? Though I had discussed aspects of termination with psychotherapy supervisors, we had never discussed how to end therapy for financial reasons. Informed consent for psychotherapy could include a discussion of termination at the very beginning of psychotherapy, including development of a contingency plan should therapy end abruptly (4). With planning, we could have transitioned my patient's care to the local community mental health center.

My unplanned termination ended surprisingly well. My patient set realistic goals to address her financial situation. I provided a referral to her community mental health center, and she called for an appointment. She remarked that she felt prepared for the challenges ahead. She revealed to me a challenge for which we all as therapists must prepare ourselves: helping our patients obtain care in trying financial circumstances. Clearly, this is an important area for further research and education.

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Who Is Right?

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My patient inquired, "Do I really need this medication? Why am I still taking it?" She was a delicate, 50-year-old Bosnian woman who spoke with accented English. This was her second visit to the mental health clinic after recent discharge from the inpatient unit where she had been admitted for a first episode of psychosis while on a trip to Bosnia. As she looked at me with an inescapable stare and faint smile that made me squirm in my chair, I replied, "You are on risperidone. It is an antipsychotic, which means it's a medication useful for problems with thoughts or how we think." I deliberately spoke in a tone that I hoped would inject some gravity into my subtle hint at why she was taking it.

"There is nothing wrong with my thoughts or how I think. When I was admitted to the hospital, I was told that I needed this medication for problems with attention, but as you can see, my attention is perfectly fine. So why should I take this medication?" As she spoke these words, I wondered if she worried about a resident her son's age prescribing her medication she didn't want to take.

I responded, "You were not yourself for the last few months, and your husband and son were concerned about how you were thinking and behaving. This medication has already helped you and should continue to help you." Not knowing what else to say, I had hoped that would be the end of the discussion.

"You barely know me. How can you say I was not myself?"

"You are right. This is only our second meeting. However, I did speak to your husband last time and also reviewed records from the unit to which you were admitted. So I was able to have a good understanding of how you were for the last few months." The incredulous expression on her face made me wonder if I had said something unintelligible.

Bending forward in the chair, hands clasped together, as if this was the moment of truth for her, she asked, "How can you say that my husband is right and I am wrong?"

A bit exasperated, I replied, "I know you are frustrated because you think I don't believe you. It's possible that your husband is not right. However, do you think it likely that your family in Bosnia, your husband, your son, and multiple doctors who cared for you in the emergency room as well as in the inpatient unit are all wrong?"

"What if all these people are wrong?" She asked this in a calm voice, with an unshakable conviction that signaled to me she had discovered a fundamental assumption in the heat of our discussion, an assumption she considered to be flawed.

I had not bargained for a profound discussion of the ethics of the right of the majority or the experts to decide who has mental illness and is in need of treatment, especially since I had just walked into the clinic that morning for my first medication management "case." However, it was then that I understood that if I didn't relax my rigid stance and open my mind to my patient's experience, I couldn't expect her to continue the treatment she clearly needed.

"You are right in asking that question. Sometimes most of the people, even professionals, may be incorrect. However, that happens rarely. In your case, I do believe that you need this treatment and would very much like for you to continue it."

All this time, it seemed that is all she had needed to hear from someone else. Suddenly, her frown vanished, her body posture relaxed, and she uncrossed her legs. "I just don't want to take whatever the name of that medication is forever. I still cannot believe that my own family for whom I did so much would call police on me to get me admitted to a psychiatric hospital and still not believe me when I say there is nothing wrong with me." Her eyes began to well up.

I then realized that granting her that remote possibility—that she was not in need of treatment—had validated her stance on the matter, a matter that had clearly meant to her much more than it had initially meant to me that morning (i.e., just another medication management case to be probed for any side effects, compliance, and possible changes in the dose). To her, the ongoing care possibly meant an affront to her self-esteem because suddenly her voice didn't matter as much. However, she must have known at some level that she needed the treatment. Why would she have agreed to it otherwise? What an ambivalence to deal with! Is this how it feels to be a psychiatric patient? Indeed, how could my patient have been expected to believe that others were right when others didn't believe that she may have been right?

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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