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THE LEARNER'S VOICE

Holding On to Hope in Frustrating Patient Scenarios: A Psychiatric Resident's Perspective

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As my intern year comes to a close, it is through this quiet contemplation of narrative medicine that provides me a relief, a way to fully comprehend these past events and to continue to grow as a young psychiatrist.

> She was a young woman, sitting alone in the exam room.
> She cried and grabbed my wrist, asking for help.
> Every punch to the stomach
> Each slap to the face
> Black and blue bruises
> She wanted to leave him. Their marriage was over.
> Over the course of the hospitalization, we discussed the assignment of a case manager and domestic violence shelter options.
> However, he promised he would stop hitting her.
> Her ultimate decision: to return to her husband. She wanted to go home to him.

It was frustrating and it physically hurt me to listen and watch. We try to help our patients "make the right decision," getting our patients to take medications or, in this case, leave their abusive environment. However, despite our best efforts, we can only do so much. The best we can do is to educate the patient, provide available resources, and discharge the patient from the hospital, hoping for the best. Sometimes that is the only thing we can do. Throughout this process, I have had instances where I question myself, Why? Why do we keep doing this, if our patients continue to refuse to take medications and engage in social work interventions or fail to show up to any of the outpatient psychiatric appointments that we painstakingly booked several weeks in advance? Perhaps, I should just embrace this nihilistic view of the world and therefore be apathetic. It would, of course, be much easier. However, I cannot. We cannot. And it is such experiences throughout my first year as a practicing physician that serve as a reminder of why I entered medicine. In such frustrating cases, there is hope that we did indeed reach our patients.

On the last day I saw my patient, she told me, "Thank you… I really appreciate it. You may not know it, but you saved me." The hospital, she stated, was her haven, a place where she felt safe and supported; the treatment team listened to her story and acknowledged her, not only as a patient, but as a person. Now, rather than seeing herself trapped in a hopeless situation, where she initially thought her only escape was through death, she could reach out to social workers, crisis shelters, therapists, and physicians; she realized that she was not alone and that there were resources to receive further help. She felt hopeful for the future.

Residency is a daunting journey. Psychiatry itself is particularly challenging; psychiatry is uniquely positioned in that our primary modality to diagnose and treat is to first unearth the unresolved traumas and emotions that come with the narratives. However, in these instances, we are not only discussing the patients' vulnerabilities, but we must also confront our own. In psychiatry we talk heavily about transference and countertransference, and to some extent, we become emotionally tied to our patients. Perhaps it is because of this emotional tie that when our patients do not meet our expectations of what we think is best for them, it is undoubtedly more painful for us; our patients' stories become intertwined with our own.

Understandably, while we may not agree with our patient's decision, we must remember not to overstep our bounds, should we be practicing paternalistic medicine. As physicians, we are here to help educate the patient and provide resources and support. We are also here to listen to our patients and bear witness to their traumas. Active, respectful listening is impactful and can restore a patient's control over her own narrative when it has been silenced for so long; this process itself can be restorative and healing to the patient.

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These experiences serve as a reminder that when we feel we are "doing nothing" to help our patients, every action we take, listening to a patient, starting a new medication, or coordinating with social work to provide resources, has potential impact. Although our efforts may not have an immediate effect, we must continue to try and hold hope that while our patients may refuse to take medications or leave an abusive environment, every time we keep offering help, our patients are encouraged to take that first step.

I will continue to carry on this message of resounding hope. I will be reminded of the time when I sat with my young patient and listened to her story, that she was provided crucial shelter and safety resources. There is hope for all my patients that they will get better as they embark on their personal journeys, a journey that I too will take alongside them as I continue through residency.

Declarations

Disclosures This manuscript reflects a generalized patient care scenario and the patient was deidentified in adherence to the standardized confidentiality protocol. The author states that there is no conflict of interest.