Academic Psychiatry (2023) 47:575–578
https://doi.org/10.1007/s40596-023-01918-y

EDITORIAL

# Hopes and Fears: Things We Need to Hear

**Adam M. Brenner[1] · Richard Balon[2] · Eugene V. Beresin[3] · Mary K. Morreale[2] · Anthony P. S. Guerrero[4] · Alan K. Louie[5] · John Coverdale[6] · Rashi Aggarwal[7]**

Published online: 5 December 2023


*Academic Psychiatry* issued a call for trainees to share their hopes and fears on entering psychiatry. The response exceeded the journal editors' hopes. The journal received far more excellent submissions than we could publish, to our regret. We hope that the essays published [1] provide a sufficient representation of the wisdom and thoughtfulness of our junior colleagues. Collectively, they comprise a vibrant mosaic of the concerns and aspirations of our newest colleagues. In this editorial, we intend to simply reflect our best understanding of the themes of their contributions. We hope it will inspire you to read the essays themselves, as there is beauty in the unique individual voices that cannot be captured in paraphrasing.

## Learning (or Re-learning) What Good Psychiatry Means

Our authors have much to say about what it means to be a good psychiatrist. Several describe their aspirational goal of offering a deep and open kind of listening. Chang [2], for example, writes that "Active, respectful listening is impactful and can restore a patient's control over her own narrative when it has been silenced." Worsham [3] notes that psychiatrists cannot help but bring their own ideas about successful treatment and a good life but must continually strive to "listen to what the patient is expressing regarding how I can be most helpful." Clearly, Chang, and Worsham embrace active, validating, and nonjudgmental listening as a core role of a psychiatrist.

For some authors, the treatment alliance is central. Watson [4] observes that "so much of these patients' recovery and healing relied on a sentiment of hope," and psychiatrists must, therefore, provide "an environment that fosters hope." This kind of therapeutic hope must encompass the reality that the course may be rocky. There will often be setbacks to recovery. Reflecting on one of the major obstacles to alliance, Arif [5] helps us remember that our impact as psychiatrists is limited by the degree that the patient can join us in an understanding of their illness. Fortunately, this difficulty does not lead to despair, but "[motivates] me to see just how much and how far I can get through" to patients.

Good psychiatry cannot be practiced without an appreciation for the centrality of human connection for mental health and recovery. Lee [6] described how moving to the USA for training provided a painful lesson in how valuable the "robust social support system" at home had been to "metabolize … stress." This observation from lived experience leads to an urgent call to help patients "talk about their social disconnectedness." We cannot "view a patient as an isolated entity, insulated from others" [6]. In a similar vein, Daneshparvar [7] writes of acquiring a "psychiatric lens" that opened sight to "the story behind the symptoms and the human beyond the psychiatric illness." Such a lens helps develop empathy for those whom society might find intolerable and thus might relegate to the margins. These observations underline the value of teaching residents the essentials of attachment theory and the skills to foster secure attachment with their patients.

✉ Adam M. Brenner
Adam.Brenner@utsouthwestern.edu

1 University of Texas Southwestern Medical Center, Dallas, TX, USA

2 Wayne State University, Detroit, MI, USA

3 Harvard Medical School, Boston, MA, USA

4 University of Hawai'i John A. Burns School of Medicine, Honolulu, HI, USA

5 Stanford University, Stanford, CA, USA

6 Baylor College of Medicine, Houston, TX, USA

7 Rutgers New Jersey Medical School, Newark, NJ, USA

## Discomfort with the Power of Psychiatrists

Several authors share a concern about the power of psychiatrists and the potential for misuse of this power. They are aware that they are entrusted with a new kind of authority and see risk, but they do not approach this risk with resignation. Liss [8] wrote of how a forced hospitalization, even when necessary, can be a profound trauma for a patient but emphasizes the principles of "procedural justice" and the value of treating people "with respect, politeness, and dignity and … their rights … acknowledged," even when forcing involuntary care. Greenberg [9] observes that sometimes it is clear who needs to stay and who is safe to go, "but many fell in between, with different opinions by attendings on the same cases." What happens when the resident's assessment differs from the attending's? The author's valuable response is that we need environments where "trainees feel comfortable raising their hesitations with humility."

How society understands the right use of psychiatry's authority is always evolving. Server [10] reminds readers of "the terrible ways that psychiatry has wielded its special social status through history" and that knowing this history demonstrates the value of "a commitment to learning from the social sciences." Psychiatry's current emphasis on the recovery model and the vitality of an interdisciplinary team also provides checks and balances to misuse of authority. However, Roy [11] asks us to consider if we are living up to our ideas of interdisciplinary teamwork and listening to patients, reporting experiences of an ongoing legacy of "medical paternalism" that can lead to psychiatrists neglecting or overriding the concerns of patients or other team members. And yet, the author closes with the potential of psychiatrists "to dismantle authoritative power structures" [11]. This hope that psychiatry may be a potential source of effecting social good, as opposed to oppression, is echoed by many of our authors. Vasquez [12], writing from Colombia, offers the vision that psychiatry may "create more alliances between people and institutions in search of a common good" and that this may mitigate a society's desensitization to suffering and inequity.

## Danger of Demoralization

The authors in this collection have been drawn to psychiatry out of a sense of mission, yet even as they begin their careers, the threat of burnout is vivid. They can already feel the pressures that generate demoralization and alienation in our profession or, perhaps, have seen the results in their teachers and supervisors. Server [10] wrote of the "fear that my humanistic spark … will be dimmed, or worse, snuffed out, amid the practical and emotional tempests of a career in medicine." This burnout may then bleed into their personal lives, as Sathappan, McGowan, and Jahanforouz [13] report: "We feel torn between continuing to work through exhaustion to do everything possible for children and their families, often at the expense of sacrificing emotional reserve for our own families." These essays remind us of our responsibility as educators to serve as advocates for residents and faculty in the prevention of burnout.

Several of the authors focus on how discouraging it is to work in underresourced mental health systems. Sathappan, McGowan, and Jahanforouz [13] describe the lack of access to care and the deficits in numbers of child and adolescent psychiatrists and decry "the expectation of trainees to fill in the gaps of a porous mental health system." Lieberman [14] describes children waiting days in the emergency room for an inpatient bed as one manifestation of the US youth mental health crisis. And Musso [15] reports that "residential options for patients with serious mental illness are limited and difficult to access when available. Decreased average length of stay and inadequate number of hospital beds limit adequate acute treatment."

Different authors suggest different remedies for demoralization. Sathappan, McGowan, and Jahanforouz [13] urge us to advocate for more protected time for psychiatrists to manage the administrative and advocacy tasks that fall outside the face-to-face encounter. Simpson [16], by contrast, suggests more attention to the importance of a meaningful life outside work: "a world in which our work identities are but one facet of our ever-evolving complex selves." In a different emphasis, Roxas [17] notes, "Perhaps a way for us healers to not burn out is to be brave enough to shape Medicine to make space to feel our full humanity" and calls for us to lean in toward our emotions; rather than develop a thicker skin, what if we actually embrace our feelings and let them "galvanize us"?

Of course, each of these approaches has value, and psychiatry educators will need a multipronged approach to preventing burnout in trainees. We will certainly need to include curricula that teach effective advocacy. When residents see that their patient's care and chances of recovery are hobbled by insufficient availability of evidence-based treatments or inequitable access to them, it is the job of educators to prevent fatalism or defeatism. Though the individual psychiatrist and patient may be stymied, psychiatrists are not collectively helpless. We must teach residents how to leverage involvement in psychiatric organizations to achieve change. We should join our faculty and residents in collaborating to advocate for increases in hospital beds and increased workforce in our field, as well as the administrative time to secure resources for our patients.

## When the Work Is Also Personal

One of the key developmental tasks of residency training is constructing a healthy boundary between the personal and the professional domains. Yet psychiatry may be unique among medical specialties in the degree to which professional and personal selves are intertwined. The authors share powerful reports of how personal our work may feel.

Clinical work may lead to personal growth, and Eisele [18] describes the need for boundaries to protect the self, but the self also grows from this work: "I have picked up pearls of wisdom … that I have already applied to my own life." Eisele reminds us that we are in a profession with "the unique benefit of cultivating the personal growth of the psychiatrist … without being the patient." On a very similar note, Vasquez [12] describes seeing growth in the capacity to be "more empathetic with the people around me" radiated beyond professional settings, to all facets of life.

Sometimes the boundaries become more porous because of distinct events in the life of the resident. Jackson [19] wrote of the trepidation felt when broaching the subject of pregnancy with program leaders: "I knew they would be supportive, but part of me felt like I needed to ask for permission to become a mother during training." This perspective is a valuable reminder that graduate medical education may still be sending mixed messages about pregnancy during training. Program directors, chairs of departments, and other faculty should emphasize that the resident is not expected to put initiating or growing a family on hold for 4 (or more) years of training. With a supportive response from her program, Jackson found that her work as a psychiatrist deepened, as "my pregnancy led me to develop a whole new perspective on perinatal stress" [19].

Life events may not always be positive. McCarthy [20] reports that the experience of miscarriage made it challenging to be with a pregnant patient, illustrating that pain in our own lives impacts the ways we can be open to the experiences of our patients. The value of boundaries becomes even clearer, but the author aptly notes that, even with appropriate boundaries, "this will likely not be the last time that empathy with a patient is also painful" [20]. On a similar note, Bhalodi [21] wrote of suffering a loss during training and then feeling "helplessly unable to process your own grief as you support others." Once again, support and acceptance from the program director and mentors was essential in rebutting the worry that "your vulnerabilities will translate to others as factors clouding your ability" [21].

These essays highlight the importance of faculty support to help residents navigate the waters of self-revelation and privacy. Supervisors are vital in helping residents accept and understand their countertransference and remain connected to their patients while establishing boundaries that are healthy for both the patient and the resident.

## Cultural Competence and Humility

A number of the authors reflected on the intersections of personal identity, culture, and psychiatric care. Several discussed the value of comparative experience in different countries' mental health systems. Respino [22] described how a second residency in the USA was an aid in learning cultural humility, as one is immersed in "a deeply diverse clinical population" while wrestling with the nuances of languages and how they shape narratives. For Barth [23], a rotation in Rwanda, a "cultural space much different than my own … pushed me to consider the similarities and differences between addressing mental health in two different countries," and highlighted the differences in social determinants of health and available resources.

Different communities will bring distinct histories with psychiatry that will color their expectations of care. The authors appreciated that psychiatrists must meet patients where they are. Bala [24] noted that experience may have taught potential patients to view psychiatrists not as helpers but as "judgmental watchers and intruders." Approaches like the cultural formulation interview are vital to ensure that psychiatrists are not "contributing to the existing stigma" [24]. Malik [25] described how the stigma and distrust of mental health in Muslim communities may be best addressed by reviving old and neglected scholarly and psychological traditions within Islam itself.

The cultural identity of the resident can be a source of pain as well. Rote [26] describes how experiencing racist slurs from patients led to self-doubt and wondering "if I was too 'soft' for this field." Instead, the author's embrace of cultural identity and community became a source of particular strength in working with some patients. Supervision is, of course, valuable in helping residents decide what kind of disclosure of one's identity will be appropriate with particular patients or different settings. But it is equally important that educators support residents by setting clear limits in clinical spaces that racist or otherwise discriminatory abuse is unacceptable and not an inevitable hazard of work.

## Conclusion

In reading these honest, heartfelt, and insightful pieces, psychiatrists should draw upon the growth mindset and developmental framework that the authors exemplify. We

should celebrate the opportunity to learn from our future colleagues, who can offer fresh perspectives and feedback on how our education and training programs should optimally evolve. None of the authors, and none of the readers, is a finished product at a static point in time. Myklebust [27] does a particularly good job of evoking the clumsiness some of us remember feeling as beginners; interviewing patients "felt like I was driving a monster truck, inadvertently clipping buildings," and managing the patient's care "felt like an overwhelmed train conductor." Yet even so, the author sees how, even as psychiatrists are slowly developing their skills, they are already "empowering individuals to rediscover their inner strengths" [27]. Grossman-Kahn [28] recalls the beginning of residency and doubting "whether the skills I valued in a psychiatrist—the abilities to provide comfort, reassurance, and hope to someone suffering—were teachable." At the close of training, it has become evident that though communication skills grow slowly and subtly, the capacity to be present with and contain painful affect did indeed prove learnable.

Our hope in writing this editorial is that the community of psychiatry educators can use these papers to continue growing as faculty. With constant effort, we too will slowly and subtly become optimally successful in empowering and supporting our trainees.

## Declarations

**Disclosures** On behalf of all authors, the corresponding author states that there is no conflict of interest.

## References


1. Academic Psychiatry. Hopes and fears on entering psychiatry. https://link.springer.com/journal/40596/topicalCollection/AC_489b3e925ee4a972fc6247dcf9fdee7b/page/1. Accessed 14 Nov 2023.
2. Chang AN. Holding on to hope in frustrating patient scenarios: a psychiatric resident's perspective. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01830-5.
3. Worsham W. The stones left unturned. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01879-2.
4. Watson CM. The power of hope to heal: my call to psychiatry as a medical student. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01878-3.
5. Arif R. What do we consider as treatment success in psychiatry? Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01851-0.
6. Lee JY. The power of social connectedness: a lesson learned from training. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01783-9.
7. Daneshparvar E. The psychiatric lens: how I started to see hope through fear. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01892-5.
8. Liss A. A dilemma in coercively treating a patient. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01884-5.
9. Greenberg NR. Commitment issues: ambivalence over involuntary hospitalization. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01839-w.
10. Server S. A light in the dark. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01887-2.
11. Roy A. Reconceptualizing the role of the expert: the unspoken hierarchy in mental healthcare. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01891-6.
12. Vasquez D. Studying psychiatry has made me more empathetic in a country where people live one day at a time. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01897-0.
13. Sathappan A, McGowan G, Jahanforouz N. "The conductor of the orchestra": re-examining the training and role of a child psychiatrist. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01872-9.
14. Lieberman EE. Healing through listening. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01890-7.
15. Musso M. Failing families. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01886-3.
16. Simpson ZM. Graduation, identity, and gratitude. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01793-7.
17. Roxas N. Healer, heal thyself. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01858-7.
18. Eisele CD. Finding hope and facing fears at the partial hospitalization program. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01845-y.
19. Jackson AA. Matching into psychiatry when expecting. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01821-6.
20. McCarthy CJ. Babies and boundaries: lessons in empathy. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01861-y.
21. Bhalodi RG. Sink or swim. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01898-z.
22. Respino M. On becoming a psychiatrist twice and the unexpected pros of residency retraining. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01819-0.
23. Barth B. Reflections from a psychiatric hospital in Rwanda. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01852-z.
24. Bala B. Translating relief and fear: navigating the intricacies of psychiatry and cultural perspectives. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01862-x.
25. Malik S. Reviving the legacy: addressing Muslim mental health. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01847-w.
26. Rote SF. An Asian-American place within psychiatry. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01850-1.
27. Myklebust L. Embracing hope and the spirit of motivational interviewing. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01856-9.
28. Grossman-Kahn R. Will I know what to say. Acad Psychiatry. 2023. https://doi.org/10.1007/s40596-023-01857-8.