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Writer's Contest!

The stories that grace our cover this month are the first and second prize winners of *Psychiatric Times*' first ever writer's contest. Our third prize winner appears on page 9.

We invited you to send us your story of a single memorable patient who stood out along the way . . . the patient who taught you a valuable lesson—the one who ultimately helped you become a better psychiatrist. We were stunned by the stories you sent. Your stories told of intimate bonds forged between doctor and patient under extraordinary and dire circumstances—tales of connections shared by 2 human beings that transcend medicine and run soul deep.

It wasn't easy to choose the "best" of the many essays we received, and we thank every one of you who sent us your remarkable stories—many of which will appear in future issues.

We hope you'll enjoy these poignant memoirs (fictionalized to protect patients' identities) as much as we did.

—The Editors



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1st PLACE WINNER

The Mirror

Jessica A. Gold, MD, MS

I could see myself in her eyes, only hers looked back at me with the wisdom of her years, with rings like a tree around them to show it. She lay in bed looking up at me, flat, emotionless, defeated. I knew if she had rings I could count them—there would be around 80—but the look she gave me evoked more certainty than a number could even define. It was if she begged, "Please," and in that instant I felt torn between letting her die and, conversely, helping her want to live.

She was a physician—a neurosurgeon. She had given herself to her patients for over 50 years, but as her mind dulled and her hands slowed and she no longer worked with the mastery that she had before, her life unraveled. She lost her job, her mentoring, and ultimately her happiness. Even

(Please see *The Mirror*, page 8)

2nd PLACE WINNER

Her First Evaluation for PTSD

Nancy J. Franzoso, MD

It was many years ago, when I worked in a large city VA hospital, that I saw her. I was doing disability evaluations that morning. It had been a stressful week: we were having problems getting paper files to arrive before scheduled appointments, which caused significant strain on the clerical staff and resulted in physicians entering into exams "cold"

ie, with no medical history—a particular disadvantage in psychiatry. Staff was short on patience, and the atmosphere was tense. It was after the Iraq War had begun, and the typical initial PTSD evaluations were of veterans with combat exposure. Women patients were not so routine at that time; when I read the female name and age, I assumed her issues were war related, like all of the younger patients we were seeing at that time.

I went to the waiting area and called her name. She was a very tall, slim, attractive young woman, dressed smartly in a business skirt and jacket, wearing hose and blouse, scarf, pumps. She sat with erect, formal posture in her chair, and appeared out of place sitting among the generations of rough and tough male patients, some with canes or service dogs. My first thought was that she reminded me of a model from the 80s . . . what was her name? . . . and then I wondered what kind of work she did for the military.

It was her first evaluation for PTSD. I needed to obtain her entire history, including all the evidence needed to make a clear argument for any symptoms being related to her military experience, to support her disability claim. I had done disability evaluations for a few years, and felt efficient. I rarely kept patients waiting.

After introducing myself and orient-

(Please see *Her First Evaluation for PTSD*, page 13)

ISSUE HIGHLIGHTS

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The Mirror

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her family did not know who she was without her skillful hands and brilliant mind. Without her tools, she could not bear to live.

Hearing her story before even having met her, I felt defeated, like perhaps she was as terminal as it gets in our profession. She had tried not once but twice in the past few months to end her life. When pills failed to kill her she tried again—only to survive a gunshot that should have killed her. Everyone around her, her friends, family, and other doctors, had resigned themselves: she was determined to die and she would die. They even began to research assisted suicide and ways to

help her. But we were psychiatrists! Perhaps naively I believed, if we could not help her, then who would?

But another part of me wondered about my moral judgment. If I were her in 60 some-odd years and I could no longer practice medicine—what I hope will continue to be a source of pride and joy in my life—would I want to be saved? Would I be lying in bed, begging a trainee, with the same longing look, to put me out of my misery? Was there mercy in letting her end her life? Was it wrong and even paternalistic to want to prolong it?

I was torn. I did not want to believe we could let her die without trying to help save her, but I felt her pain. I wanted to believe there was a difference between mental pa-

thology and real desires, and if she could only get better, maybe her desire to die would change. Maybe if she were happy, she would want to live—even in a life without medicine.

Initially, we tried to adjust her medications. Each morning I would smile kindly and ask how she felt. Each and every day she would tell me with conviction that she still wanted to die and that if we discharged her, she would end her life.

The medications do not seem to be working, I thought to myself as I turned to walk out of her room . . . a fact I knew she must have been thinking, too.

One day I pivoted around to face her and said, “*Dr. T, you have so much more to impart to a trainee*

like me. It makes me sad that you want to die.”

She looked up at me again, “*What year are you in training?*” While I answered, she paused as if that time in her life was flashing before her eyes. She then quietly responded, “*It’s nice when you first start out, but not as nice in the end.*”

I wondered if she was right. I pictured myself in my old age and I worried if I, too, was resigned to the same fate . . . discouraged and hopeless, with life no longer worth living, thinking about and trying to die by my own hand. Was this what happened to all great doctors?

Yet, we did not want to give up. We had one more ace to play, which, ironically, was a tool she knew well: ECT. She had seen it decades be-

Powerful Stories—Winners of Our Writer’s Contest

Allan Tasman, MD, Editor-in-Chief

What a pleasure it is to introduce the winning essays in our inaugural *Psychiatric Times* writing contest! When deputy editor-in-chief, Michelle Riba, and I first discussed the idea for this undertaking with the editorial

staff, we had no idea we would have such a rousing response. Well over 100 essays were evaluated. The editors first reviewed the submissions and narrowed down the choices. Then Michelle and I reviewed them—we looked especially for how that particular psychiatrist’s patient experience both influenced his or her own career and illustrated a significant aspect of importance in the therapeutic alliance.

The winning essays stood out, but were by no means the only outstanding contributions. We wish we had space to publish all those who shared their stories, as each provided a valuable illustration of what is most important in our work. In coming months we’ll publish our honorable mention and other noteworthy essays, and post others on our website.

We particularly looked for universality of an aspect of the psychiatrist’s experience that can serve as an opportunity for self-reflection by those who read the essays. Finally, we asked the winners to assure us that the cases were disguised in such a way that others would be unable to identify the patients being described.

CALL FOR SUBMISSIONS
Psychiatric Times
Writing Contest!

Has there been one patient who ultimately made you a better psychiatrist?

Send us your story by [blank] by [blank]

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We are humbled by the courage demonstrated by all those who told of a patient experience that had such important personal meaning. So much of our self is involved and used in our patient interactions. So it’s not easy to let others know not only about aspects of the patient’s condition, but also about our own personal experiences and reflections in our clinical work. We thank all those who shared with us their patient experiences in such personal and heartfelt ways.

The First Place essay in this year’s contest is “The Mirror” by Jessica A. Gold, MD, MS. In her poignant description of caring for a severely suicidal patient, Dr. Gold shows not only the importance of, but also the difficulty in, maintaining an attitude of therapeutic hopefulness—even with an extremely hopeless patient.

Our Second Place goes to “Her First Evaluation for PTSD” by Nancy J. Franzoso, MD. We either already have information about the person’s history or their presumptive diagnosis for most all the patients we see. But Dr. Franzoso underlines for us the critically important fact that we should not use that information to filter what we first hear from our patients. Maintaining that stance of taking nothing for granted as we make our own evaluations is both difficult and essential—and often surprising.

This year’s **Third Place essay** is “Foster Care” by Sidney A. Kelt Jr, MD. We have all been taught about how important it is to find a way to make contact with our patient in a human but professional way as part of developing a therapeutic alliance and working relationship. Even the smallest, and what may seem to us less important, aspect of our relationship may have much greater meaning for our patients than we can imagine. Dr. Kelt’s story reminds us that even the most unlikely part of an interaction may have the utmost importance to our patients.

Even though I’ve read these stories a number of times, I still have an intense emotional response to each of them. They remind me that our work is of incredible personal importance to our patients and of such emotional meaning to us too. I know you’ll feel the same as you read them.

Dr. Tasman is Professor and Emeritus Chairman of the Department of Psychiatry and Behavioral Sciences at the University of Louisville. He holds the John and Ruby Schwab Chair in Social, Community, and Family Psychiatry.

fore, and even though it was more primitive back then, she did not hesitate to consent. Perhaps it was easier for her to place her hope in a procedure than in medication or therapy. Maybe, if we were lucky, through a procedure she might find herself again.

Each day, as I had before, I went to see her. I asked her to tell me a story from her career, and begrudgingly she complied. Each story was more fantastic than the last. She constructed an autobiography for me, and I, as her doctor but also as a trainee learning from an expert, listened intently. Maybe I was hoping to learn how to be like her. Or, maybe, I was looking for how not to be.

As expected during an ECT course, no changes were evident in the first 4 treatments. But even as we approached day 6, she still very much wanted to die.

Day 7 came and went with no change.

On day 8, however, she smiled at me. I asked her if she felt any better, and she adamantly said no. But with her grin, I regained a bit of hope.

Each procedure day afterwards, she became brighter and brighter. She smiled more often, she laughed more frequently, and she even opened her blinds to sunlight and left her room during the day. She was a completely different person than the one I had first met. I had a feeling that from the darkness, the real doctor was emerging.

As her MADRS decreased, so did my own insecurities about my future and my profession. She was getting better and we had helped her get better. She was not terminal and I would not be either. My future was not hopeless after all.

On her final day of 3 times a week ECT, she again asked me my year of training, but this time asked if I liked being a psychiatrist.

I responded, “*I am a second year, and I do. . . I think I may love it.*”

She looked back at me and said with a joking smile, “*You don’t have the hands of a surgeon, or the demeanor. It’s a good thing you are a psychiatrist.*”

I looked back at her, laughed briefly, and said, “*Is that a bad thing?*”

She reached out her hand to shake mine and said, “*If you were not a psychiatrist, who would have saved my life?*”

Dr. Gold is starting her third year of psychiatry residency at Stanford University in Stanford, CA. □

3rd PLACE WINNER

Foster Care

Sidney A. Kelt Jr, MD

As I think back over the years I have been practicing, one encounter comes to mind that has had the most impact on my development as a psychiatrist.

Soon after I finished my residency at a large, urban hospital that served the poor and uninsured in Dallas, I found myself entering the world of private practice with patients who had insurance, jobs, homes, food, and transportation. I also started working part time at a psychiatric hospital in a nearby rural town. A psychologist I befriended at the hospital joined my practice and soon asked me to become a consulting psychiatrist at the foster care agency where he worked. I had no experience with foster children, but I thought I needed to take on whatever jobs I could find while I was building my practice. It was a relatively new foster care agency, so I only saw up to 8 teenagers a month.

One of the case workers from the agency brought the children to my office every month either for a medication follow-up or an initial evaluation. The agency was well-run and took care of these children in a most respectful and kind manner. As a result, the number of youngsters in the agency grew rapidly. They could no longer be brought to my office every month in the agency van, so I drove about 20 miles to see them at the agency’s center. It was hard hearing their stories of abuse, neglect, and difficult times at such a young age. I tried connecting with these young, neglected, and unloved children—but many of them were closed off to any human connection out of fear of rejection or being moved again and ripped away from their caring foster parents. Many were angry, defiant, oppositional, and I had to build some sort of trusting relationship if I wanted them to be compliant with the medication I was recommending.

One day I decided to gather up a bunch of cool, flashy pharmaceutical pens that had been left at my office that week. More pens than we needed . . . ones you couldn’t just buy at a store. These pens had different colored lights, bright colors, liquids in them, lights to read by, etc. I brought them with me and as I finished with each encounter, I invited the child or teen to pick the pen he or she wanted. Soon the kids were requesting to be the first in line to see me so they got



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first pick of the pens. They looked forward to their visits and couldn’t wait to see what kind of pens I had brought to their visit.

One of those children was an 11-year-old boy who had been terribly hurt by family members and was unable to trust anyone in authority. He was so sad and depressed; no sparkle in his eyes. He wouldn’t talk, or look at me, and was quite reluctant to even take one of the pens. He did want to feel better though, and I promised him I could help him. He started on an antidepressant and within weeks was smiling, laughing, and enjoying life again. I saw him every month for the next 3 years, and he manipulated the case workers so he could be seen first nearly every time to get the best pen. He would show his latest pen off to the other kids waiting for their appointment.

Unexpectedly, the boy was moved to a new foster home where his older sister lived. I didn’t even know where he was staying. I felt bad not getting a chance to say goodbye to him.

It wasn’t long after this encounter that the pens stopped coming to the office so I had no more fancy pens to bring to the children. By then I was visiting the agency twice a month and seeing 24 children.

Two years passed. And then one day the same young boy’s name was once again on my schedule. No one told me he was back at the foster care agency and that he was scheduled to see me.

When he came into the office, I hardly recognized him; he was wearing braces, growing facial hair, and had developed into a young man. He gave me a hug and sat down in his chair. When I asked what brought him in to see me, he said, “I don’t need any medication, Dr. Kelt. I just told my case worker I was depressed so I could come see you. I missed our talks and I missed my pens.”

I laughed and realized he still knew how to manipulate his way to get what he wanted and had to break the news that I no longer had any pens to offer. He grinned and said that was okay. Then he reached down under his chair and pulled out a shoebox and placed it on my desk. He asked me to open the box, and when I did I saw every pen that he had been given over the 3 years I had seen him. There must have been over 40 “one of a kind” pens in that shoebox. He looked up at me, got a little teary-eyed, and said he took them everywhere he went over the 2 years he was gone. He had changed foster homes multiple times but never gave up those pens. He told me that no matter where he was, he always felt connected when he had his pens.

I had no idea how important those objects were to him, or how important his relationship with me was to him until that moment. When you have been neglected, made to feel so unimportant, passed around from place to place as though your life doesn’t matter, any genuine caring attention you can give that young person means the world.

The boy stayed at the agency until it was time for him to graduate, and he left with his box of pens.

I continue to work at the foster care agency, and it has now been 28 years. I drive there 3 times a month and bring a third-year medical student with me as part of her psychiatry rotation. I have no more pens, but sharing this experience with my medical student is the most effective way I can teach young physicians the importance of finding a way to connect with their patients.

Dr. Kelt is Assistant Clinical Professor at Texas A&M Health Science Center, and Psychiatry Clerkship Director at the Dallas Campus of Baylor University Medical Center. He also has a private practice in Dallas, TX. □

Her First Evaluation for PTSD

Continued from page 1

ing her to the nature of the exam, getting the basic information about her military history, I told her the unfortunate reality: that I had not received her file as yet. The stylish woman sitting with her legs folded business-fashion suddenly slumped over in her chair in disappointment. I apologized for the inconvenience, reassured her that I would get her file in the next day or two, explained our department dilemma with paper charts. I rationalized that “all it meant was a little more for us to talk about,” so that I understood her history completely and did not miss anything. She was silent for a long time. Then, she looked up, made direct eye contact and asked simply, “Could I just show you?”

I was confused. It was an unusual question, and I had no idea what to expect. Of course I wanted her to feel comfortable, in control. Still, I needed to obtain a lot of information and the clock was ticking. I had another patient scheduled immediately after her appointment.

“Oh, yes, of course,” I said, preparing my notepad. She heaved the heaviest sigh I had heard in a long time, then slowly and deliberately stood up out of her exam chair. Ever so slowly, she took off her blazer and placed it gingerly on the chair. She pulled up her silken blouse, carefully unbuttoning all of the buttons. She gracefully removed each arm from the blouse, as her fingers began to faintly tremble. As she stood there in her bra and skirt, still in her pumps, I contained my own gasp. Her torso was a jumble of long, discolored, raised but well-healed scars. She stood there, and as tears started to well up, I asked her softly, “What happened to you?”

“My husband did this to me,” she said, as tears slowly flowed down her cheeks. I stood up and offered her blouse. “It’s OK,” I said, “you’re here now.” She put her blouse and jacket back on, wiped her tears, and sat down. Another heavy sigh came forth.

“Help me understand what happened,” I said. And then the story came. She and her husband had met in the military, and lived together with their child on base. He had some problems with authority, got in trouble a couple of times, had been in alcohol treatment. At one point he started to become violent. She was concerned for the safety of her young child. They had been in couples counseling for a while. Nothing seemed to work. With the help of her

To be ultimately available, we need to be prepared to surrender any planned script for our interviews . . . clinic protocols and schedule constraints be damned.

counselor, she filed a restraining order, had the door locks changed in their small apartment on base. They were in the middle of divorce proceedings when one night, her life changed forever.

She and her child had gone to bed early. She had read the toddler a story, and the little one had fallen asleep next to her in the big bed where her daddy used to sleep. Hours must have passed as they were both deep asleep, when she was awakened by a stabbing pain and her child’s screams. The last thing she remembered was her husband attacking her, and trying to guard her child from the knife. She woke up in the ICU.

Her husband had stabbed her almost 30 times. She suffered a lacerated liver, fractured ribs, a collapsed lung. The MPs were called to the apartment by neighbors, who heard the screams. Her husband was arrested. Miraculously, her child was unharmed.

“When I was in the hospital, all I could think about was my baby, and how did he get into the apartment?” she said. She recalled being “hysterical with worry” upon waking, until she could see for herself that her child was OK. She later learned that her husband had talked a barracks guard into letting him in by feigning that he had misplaced his keys. The

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guard evidently was unaware of the restraining order or the changed locks. It took months in the hospital for her to recover. While she was hospitalized, the child stayed with the woman’s parents. Her husband faced trial and was dishonorably discharged from the military. She was unsure of his current whereabouts, but hoped he was still in jail.

When her medical file arrived days later, to my surprise, it was not much help. Due to the legal nature of the proceedings and the privacy rights of her husband, no details of his trial or sentencing were evident in my patient’s chart. The only evidence to support her story was an emergency room triage note, which I might easily have missed in a brief review.

The most valuable evidence I obtained was the removal of my patient’s blouse, so I could see the extent of the injuries firsthand. How often does a psychiatric patient choose to disrobe rather than describe abuse, I wondered? She suffered from symptoms of severe PTSD, particularly with insomnia

and nightmares, as she still found it difficult to trust that she and her baby would really be OK, asleep, through the night.

This woman’s abuse and resulting VA disability examination occurred over 10 years ago, many years before the development of the current MST (military sexual trauma) protocol, which helps support victims of sexual and domestic violence suffered during their military careers. In retrospect, my patient was fortunate that she was randomly assigned a female examiner—not a common practice at the time, which may have helped her feel more comfortable revealing her injuries.

What did I learn? Stuff I thought I knew. Maybe I needed reminding. First: ignore any preconceived notions about who you think your patient is—ie, be open and flexible. Next: the most valuable tool we have as psychiatrists is the ability to listen—with all of our senses. We never really know what will come up when we open a patient’s treasure chest of emotional history. To be ultimately available, we need to be prepared to surrender any planned script for our interviews . . . clinic protocols and schedule constraints be damned.

Most of all, I was reminded once again of the strength and resilience of the human spirit. I will never forget her. I was blessed and inspired that day, by a very beautiful, strong, and unusually graceful young woman, mother, and veteran.

Dr. Franzoso is in private practice in Boulder, CO. □