On being useful

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During a tutorial at medical school I was asked to take a psychiatric history from a severely depressed woman. As was common practice, the interview took place in front of the six or so other students and my tutor. I managed to supress my awkwardness about the fact that the patient was being asked to share intimate details with an audience of strangers (Why did she agree? Does she still want to be here? Should I stop the interview and ask if she's okay?), and listened as she described symptoms of true melancholia, complete with the accompanying cognitive and physical slowdown.

When the interview was completed and the patient went back to the ward, the tutor asked me how I felt. I wasn't in the habit of asking myself that question, so it took me a few moments to process. I realised that I felt terribly, terribly sad. The other students admitted to feeling the same.

The tutor went on to say how normal this response was and that the difference between our experiences as students compared to when we became doctors was that we were not yet useful to the patient. This made sense. As a student, I had nothing to offer the patient except for my listening. That meant that I was simply sitting with her in her pain, without any strategies to help her get out of it.

When I graduated and started working on the wards, I remembered this advice and it seemed to play out. Now when faced with suffering I had something to offer, whether it was the flick of a pen on a drug chart, a referral or a telephone call to a registrar or consultant for help with the immediate problem.

When I started in general practice, I again recalled this advice about usefulness as I again found myself shaken up by my contact with patients. In the confines of the consulting room I realised I was once again sitting face-to-face with suffering. And once again I felt useless. As my skills as a general practitioner improved, it got better: I had medications and strategies and referral networks to offer. But I was also finding that some of the mental health problems I was seeing didn't fit DSM-IV diagnoses. Instead, they fit under headings such as: 'burnt out', 'overwhelmed' or 'stuck'. I became interested in learning ways to work with these patients and found myself asking more experienced GPs for advice, some of which surprised me. One GP suggested that I encourage a patient to just 'sit in the stuckness' and see what happens. When I measured this strategy up against my yardstick of usefulness it came up lacking. But in some cases it really worked and I started to wonder if my idea of usefulness needed some revising. Sometimes the answer to a problem is to look for ways to fix it. Other times – as many Eastern wisdom traditions have been saying for centuries – it is enough just to sit with it.

The focus articles in this issue of *Australian Family Physician* relate to focused psychological strategies, and I thank the authors for providing both a basic introduction of the indications and processes of each and pathways for further study for GPs who are so inclined. Each approach suggests a different way of dealing with patients with psychiatric symptoms or resistance to change who are also feeling 'stuck' or 'overwhelmed'.

Working with patients in the 'spirit' of motivational interviewing,[1] involves suppressing the urge to tell patients what to do (resisting the *righting reflex*) in order to allow them to explore their own motivations for change; problem solving therapy[2] involves encouraging patients to clearly define the problem(s) and deal with one problem at a time; in cognitive behaviour therapy,[3] patients are encouraged to challenge unhelpful thought patterns; and acceptance and commitment therapy[4] teaches patients to approach uncontrollable experiences with mindfulness.

Feelings of being 'burnt out', 'overwhelmed' or 'stuck' are common to the human experience of life as well as to psychiatric disorders. It is important to keep learning strategies to deal with these feelings, often by guiding the patient to find and embrace their own reasons for change, as outlined in this issue of *AFP*.

Equally important is to keep looking at and expanding our own concept of how we can be useful in the consulting room. With some patients, fixing is not quickly within reach and our most important tools are our listening and our ability to sit with their suffering. This is both simple and extremely difficult. And extraordinarily useful.

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References

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