The challenge of 'holding space' while holding the pager

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At morning shift change a few months ago on my consultation-liaison rotation, I thanked the night float resident who had been called to a case that was not at all psychiatrically acute. When I told my colleague I was sorry she had had such a "soft consult" during a busy shift, she graciously replied that the patient had been exceedingly pleasant. She said, "Sometimes we just offer our presence, and you know what? I'm glad I'm in that kind of field. The 'being-present' kind of field."

As mental health professionals, we pride ourselves on being present for our patients and our colleagues alike. Winnicott[1] originally coined the psychoanalytic term "holding" to denote one of the earliest stages of parental care, wherein an environment of both physical and emotional reliability allows a child to develop their sense of self. The complementary concept of "containing," developed by Bion,[2] indicates a parental figure's receiving the child's emotions, however difficult, and then processing them into a more tolerable form. I am frequently struck by how often our role as psychiatrists is not necessarily to offer a specific diagnosis or medication recommendation, but instead to "hold" by listening, "contain" whatever emotions emerge, and offer a sense of validation and perhaps a biopsychosocial formulation for the patient's experience.[3-5] In the consultation-liaison setting, we might assess the contribution of sleep cycle disturbance, postoperative opioids, and anticholinergic medications on a patient's mental status. Just as important, we might help the patient and their primary team understand that the patient's history of childhood trauma could, under stressful conditions such as a prolonged hospitalization, lead to affective dysregulation and result in projective identification through which the team felt just as frustrated and helpless as the patient.

The relentless pursuit of efficiency vs time spent with patients

In inpatient work, I may serve as short-term psychotherapist for the patient, their family members, or a consulting team, and I treasure the time spent in those roles. But I concurrently hold various other responsibilities during my shift, including the roles of triage clinician, medical ethicist, and psychopharmacology expert (or, in the case of a newly-third-year resident such as myself, a nonexpert trying to build her knowledge base). I am also literally holding a pager, which intrudes—with aggressive cacophony, vibration, or both—upon the sanctity of any space. The pager is a reminder of a myriad of tasks: calling collateral, answering questions from team members, pre-charting, note-writing, ordering labs, checking labs, updating the handoff, reconciling medication lists, filling out legal

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paperwork, triaging the next consult. These are unavoidable and generally necessary parts of clinical work, but sometimes they veer into sheer drudgery.

As a medical student, learning to complete tasks is a substantial part of each clinical rotation, and task completion provides plenty of dopaminergic reinforcements that could masquerade as job satisfaction. Through my first year and a half of residency, I pushed hard to build "efficiency" in my workflow, but eventually, task completion stopped providing sufficient inherent satisfaction. It has been a relief to find that amid the stream of checkboxes, the true work of psychiatric care (the interactions with patients, their clinical presentations, and considering their differential diagnoses and treatment options) feels deeply meaningful and ever more fascinating.

At times, I am angered by the reality of limited clinician bandwidth. This frustration motivates me to seek system-level improvements that can enable us to deliver quality psychiatric care while mitigating the risk of clinician burnout. What ends up shortchanged in the relentless pursuit of efficiency is the time spent with patients. This is never more apparent than during a busy inpatient shift, when I often need to compress patient interactions and focus only on the most acute clinical questions. When I have to apologize for stepping out of the interview room to answer yet another page, I marvel at seeing attending psychiatrists who—with apparent ease—make patients feel as if they have all the time in the world, and I wonder when I will be able to do the same.

And yet, there are other times when my pager stays blessedly quiet, time can slow down in the room, and I can make a patient feel heard, held, and contained. In those moments, I also hold my own need for connection with the patient, and can recall what my colleague reminded me: what a privilege it is to be in the "being-present" kind of field.

Clinical Point

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References

1. Winnicott DW. The theory of the parent-infant relationship. Int J Psychoanal. 1961;41:585-595.
2. Bion WR. Learning from experience. William Heinemann Medical Books; 1962.
3. Green SA. Psychotherapeutic principles and techniques: principles of medical psychotherapy. In: Fogel BS, Greenberg DB, eds. Psychiatric care of the medical patient. 3rd ed. Oxford University Press; 2015:191-204.
4. Griffith JL, Gaby L. Brief psychotherapy at the bedside: countering demoralization from medical illness. Psychosomatics. 2005;46(2):109-116. doi:10.1176/appi.psy.46.2.109
5. Nash SS, Kent LK, Muskin PR. Psychodynamics in medically ill patients. Harv Rev Psychiatry. 2009;17(6):389-397. doi:10.3109/10673220903465726