Knowing When to Ask for Help and How to Get It

A Guide for Postgraduate Fellows in Psychiatry on Considering Personal Psychiatric Consultation and Treatment

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Introduction

The faculty of the Yale Department of Psychiatry welcomes you to your postgraduate fellowship and takes a special interest in your personal and professional growth and development. This guide grew out of the faculty's concern for your well-being during your postgraduate fellowship. It was designed to alert you to the possibility of emotional strain or difficulty during your training and to encourage you to seek appropriate professional consultation. The faculty considers your taking your own mental health seriously to be a sign of strength and maturity, and we have developed this guide to support your recognition of potential problems and to facilitate you getting the help you need. In advising you about how to seek help for emotional difficulties that can arise during postgraduate fellowship, this guide is meant to supplement, not replace, personal conversations with family, friends, colleagues, physicians, faculty advisors, and mentors. In this guide, we detail many of the stresses and strains of internship and residency, especially those specific to psychiatric training. We look at the interplay of adult development and cultural differences with the challenges of postgraduate training. We examine the kinds of vulnerabilities that fellows bring with them to their training. And we consider how to decide whether professional help is indicated and, if so, how to get it.

The Challenges of Training

Postgraduate fellowship in psychiatry can be a fascinating and enriching learning experience. After years of intensive study of the basic and clinical sciences in medical school, PGY 1's have a rigorous first year of applying that knowledge with patients during various medical and surgical rotations. PGY 2's begin your specialty training in psychiatry fulltime. The field of psychiatry is in an exciting phase of growth where the rate of knowledge acquired within our discipline is expanding exponentially. Whether your interests are in research of the molecular biology of the brain or in the diagnosis and treatment of patients or both, there is much to learn and apply as you progress in your training.

As with any new, intensive learning experience, psychiatric residency can also be challenging. At times, it can be frustrating, overwhelming, frightening, sometimes discouraging. There are many reasons for this. An important one is the model of learning during residency. Psychiatric residency requires simultaneous immersion in many different aspects of the field. You will be taking courses in the molecular biology of the brain as a foundation for learning psychopharmacology. You will be studying the complex interface between psychiatry and medicine. You will learn about the various ways that psychopathology manifests itself and the different courses and outcomes of psychiatric illnesses. Seminars in child and adolescent development will lay the groundwork for understanding and working with adults. You will be learning how to

interview patients, make differential diagnoses, and initiate treatments. You will meet patients who suffer with many different kinds of psychiatric and emotional disorders. No one excels at everything. We recognize that some aspects of training will be more difficult than others.

Most residents find the clinical encounter with a wide variety of emotionally disturbed and disturbing patients- arguably the crux of psychiatric training- a challenge. After all, in order to learn how to practice psychiatry, we ask you to sit with other human beings who may be in the midst of a terrifying psychotic disintegration, backed against a psychic wall, cowering in a corner of delusional misperception and paranoia. Or we ask you to listen to someone who feels such abject despair, hopelessness, and self- lacerating guilt, is so haunted by horrifying internal dybbuks and persecutory demons that they feel driven to end their very existence. You might hear the story of someone who has been raped or tortured, or has been in violent and brutal combat, or who has witnessed their child being killed in an accident. Listening to such dramatic and moving stories is difficult. How, then, do we learn to sit with and listen emphatically to people who suffer from and with such intense, overwhelming emotional disturbances without becoming so overwrought ourselves that we are useless as helping professionals or so detached, inured, unaffected by the person's story that our interaction is mechanical, impersonal, just going through the motions?

Psychiatry: A Special Form of Listening

As psychiatrists, we are medical specialists in the diagnosis and treatment of mental disorders. Our purview thus includes the biological, sociocultural, and psychological factors that cause mental illness and emotional suffering. For psychiatrists, listening to a patient involves a *complex form of listening.* As physicians, for example, we listen for symptoms and observe signs of formal psychiatric disorders as well as being alert to any evidence of medical and neurological disorders that may have a psychiatric presentation. As social scientists, we listen for the stresses and strains in the patient's social environment- family, friends, work, school, cultural milieu- that may have precipitated or contributed to the onset of the disorder or may serve as useful resources later if treatment proves indicated. As scientists of the mind, we also listen to the patient's story- it's form and content, *what* is said and *how* it is said, what *is* said and what *isn't*- and note what the story reveals about the psychological make-up of the person- strength, weakness, patterns of conflict, sense of humor, developmental crisis, passion, inhibition, introspection, intellect and talent.

And we listen in another way, too. We attend to our own internal dialogue about what the patient tells us. Always curious, we allow a flood of silent questions to permeate our thoughts as we listen. Is the patient's speech easy to follow or difficult? Does the patient's story generate a sympathetic reaction within us or an antagonistic one? Are we interested or bored? Does the story move us emotionally in some discernible way? Do we find ourselves feeling sad or anxious, irritated or offended, intimidated or fearful, self-doubting or demeaned? Do we find the patient's story funny and if so, do we feel like

chuckling to ourselves, laughing out loud, or belly laughing so loudly that we could be heard down the hall? These internal reactions to our patient's story provide us important data to consider in our evaluation.

And from these widely different ways of listening, we begin to construct a diagnostic model that weaves into a coherent formulation how and whether and with what weight the various biological, sociocultural, and psychological factors contribute to and interact with the presenting illness or problem. This formulation then helps us devise a preliminary treatment plan that we revise and refine as we continue to listen to the patient. While this seems straightforward enough, there are hidden emotional risks to this kind of clinical listening.

Hidden Liabilities of Therapeutic Listening

It is a paradox of our profession that listening- the fundamental diagnostic instrument of psychiatry upon which all our efforts to understand and help the patient is based- may also cause psychiatrists and psychiatrists-in-training to be more vulnerable to emotional strain or difficulty than other medical specialists. It is well documented in the scientific literature, for example, that listening to certain kinds of stories has a more profound and enduring effect on the listener than other stories. In particular, listening to stories of catastrophic trauma- stories which depict events involving actual or threatened death or serious injury such as military combat, violent personal assault, being kidnapped or taken hostage, torture, being a prisoner of war or in a concentration camp- is often profoundly unsettling to the listener. On occasion, even the listener herself may develop symptoms of a traumatic stress syndrome, a process known as secondary traumatization.

Another way patients may powerfully affect the listener is less by the content of their story and more by the compelling way they interact with us. A patient, for example, may directly and insistently demand things from the listener, and the listener may experience these demands as virtually irresistible. The pressure exerted on the listener to yield to the patient's forceful demands may lead to inappropriate or even dangerous interactions between clinician and patient- all under the listener's self-deluding guise of rescuing the patient. In a further possible complication, these demands sometimes remain unspoken and are expressed subtly and nonverbally, and as a result, may apply even more powerful, through indirect pressure on the listener to comply. Patients with addictions, a history of sexual abuse, or with severe personality disorders are especially likely to present this way during clinical encounters. These types of clinical interactions are some of the most difficult to handle even for experienced clinicians. And yet it is extremely common for postgraduate fellows to work with such patients on a daily basis.

For example, a situation may develop where the patient, desperate to assuage some unbearable state of anxiety, despair, and craving, demands that his doctor provide a "quick fix" to his problems. The fellow, also wanting to assuage her barely tolerable, though expectable insecurity about her new professional role- what do I say? what do I do? how do I handle this?- desperately wants to help her patient. These forces

sometimes converge in the resident's *overly* identifying with the patient's plight and seeking to rescue the patient in unprofessional ways. The patient, for example, might demand explicit signs of caring on the part of the treater, stating or implying that without it, he might end his life. Such pressure is an expected part of treatment with more disturbed patients and both novice and experienced clinician alike will find it hard to bear. These demands for instant gratification leave the therapist precious little time and space to think. Given such *apparent* clinical "catch-22", the challenge is to find a way to help the patient in a responsible and professional way.

Sexual seduction by or of such a patient or the violation of other professional boundaries is unfortunately a real and significant occurrence in our field today. The effect of such an occurrence for the patient is often to magnify and deepen his previous difficulties as well as to exacerbate problems of interpersonal trust of other helping professionals so as to jeopardize effective future treatment altogether. The effect on the resident's personal life and future career- including professional embarrassment, professional liability, censure, or even temporary or permanent loss of medical license- can also be devastating. Learning how to deal with such interactions before they result in boundary violations is a vital and integral part of residency training, but one that obviously can cause substantive emotional strain on the fellow.

The Anxieties of a New Professional Role

These expectable insecurities related to adopting a new professional role, mentioned above, are commonly experienced during psychiatric training. As *novice* psychiatrists, you may find that the *patient's* anxieties intrinsic to his emotional difficulties as well as those stirred by presenting anew to a stranger for evaluation and treatment resonate with *your* anxieties about taking on this new professional role with all its attendant responsibilities. The patient may be worried whether or not you can be of help. Indeed, you, too, may wonder whether or not you can be of help. After all, you are still acquiring the knowledge and skills that can eventually result in competence in this new role. How does a resident know if professional self-doubt is realistic, based on inexperience with the new role, or exaggerated, based on predisposition to personal insecurity? To confuse things even more, who among us has no predisposition to personal insecurity?

Even though such feelings of self-doubt may be natural and understandable, they may not *feel* that way at all. Such insecurity may in fact feel like a confirmation of a fatal professional or personal flaw. If these new insecurities align with old ones, the problem is only intensified. Afraid of acknowledging such concerns to a colleague, trusted teacher, or mentor, the resident's self-esteem plummets while having the added burden of trying to appear confident, in control, comfortable in the new role.

Another source of emotional strain during training may arise from working closely with a highly competitive group of postgraduate fellows who are all striving to establish themselves in their new professional role. Cohesive group dynamics can break down into conflicting ones of scapegoating or clique formation. Subjecting your clinical work,

grant writing, and research efforts to the regular scrutiny of supervisors, ward chiefs, and research mentors may offer rich and valuable opportunities for learning, but it also exposes your work to criticism which, even if well-meaning, may compromise your confidence, enthusiasm, and self-esteem. Early in your career, it may be difficult not to take such criticism too personally and overreact to it.

As postgraduate fellows, the patients you will see are among the sickest and most complicated you will ever encounter during your career. With some patients, the sheer foreignness of their internal worlds can be chilling, disquieting, even repellant. You may be tempted to see them as "other", almost as non-people. You may feel at a loss as to how to connect with them. On the other hand, you will also see patients, for example, in the Long Term Psychotherapy Program- who seem quite similar to yourself. They may be near your age and facing similar issues in the course of their lives; they may speak of familiar shadows of self-doubt. Working with these "healthier", higher functioning patients may add to the insecurities of adopting your new professional role. Such patients may make you doubt yourself again: "what do I have to offer such a person?" These doubts can increase the work-related stress that you already experience.

So, how might a personal psychotherapy be helpful to you? Talking regularly with your own therapist can significantly diminish or relieve your level of emotional distress, pain, and anxiety. And while your treatment is obviously for your personal benefit and development, professional development can be a welcomed by- product of ongoing treatment. If you have sat in the patient's chair yourself, you may be able to listen to your own patients in more empathic ways that can make you a more effective, sensitive, and perceptive clinician. Ideally, you will experience first hand how psychotherapy can help you and you will then be better able to help others. You may be surprised to discover that people can change in psychotherapy. Your decision, however, whether or not to participate in therapy is a private one; it is not a Program or professional requirement.

Supervision

But let us be clear about consultation and treatment. People enter treatment because they are suffering, because of persistent emotional distress, because they are struggling with some old problem that will not yield to one's own efforts. Even though there may be some serendipitous educational benefit, personal treatment is not the best place to learn how to conduct psychotherapy. That is the role of supervision. If you find yourself having difficulties working with a particular patient, supervision is the ideal place to discuss such problems.

Sitting with patients in a treatment relationship can stimulate powerful feelings. Some patients can make us feel frustrated, angry, enraged. Others can stir feelings of inadequacy, impotence, or helplessness. Certain patients can evoke in us anxiety, feeling intimidated, even outright fear. Sometimes we find we cannot shake these powerful

reactions when we leave work. We may become preoccupied with patients. We may worry about them, dream about them, perhaps even dread seeing them again.

We encourage you to discuss openly and fully such reactions to patients in supervision. A good supervisor welcomes the therapist's emotional responses, whether mild or intense, to her patients as vital and regular part of our everyday clinical work. In supervision, you will learn how to use such reactions as an important source of information about the implicit or unspoken aspects of the treatment. Distressing or unsettling reactions to patients are compelling indications to discuss such cases in supervision. But if you recognize such reactions as occurring repeatedly or especially limiting your clinical work or if such reactions are old, familiar ones that have previously had repercussions in your personal or work life, then private, professional consultation may prove illuminating and beneficial.

Rowing Upstream: A Sea of Change in Health Care Delivery

Learning the complexities of a new professional role occurs against a backdrop of the dramatic shift in the socioeconomic and political realities of health care practice and delivery in the United States and the particular impact that shift is having on the practice of psychiatry. This includes dramatically reduced lengths of stay in inpatient units and corresponding diminished numbers of outpatient visits. This has necessitated that sicker, more chronic patients are assessed, treated, and discharged in a much shorter time and are then referred to already strained outpatient systems. Psychiatric fellows, often the front line clinicians in these situations, may experience significant conflict between the ideal standard for treatment they are being taught during psychiatric training versus the everyday standard of treatment that is feasible and realistic in this high volume, fast paced climate of mental health care delivery. New to such realities, psychiatric fellows may at times feel discouraged at the limitations of our current treatment systems. Sometimes psychiatrists-in-training can feel overly responsible for these limitations.

The Challenges of Adult Development and Psychiatric Training

Interns and residents may begin their psychiatric training at different times in their lives. Some postgraduate fellows are young adults, having begun their training immediately following college and medical school. Others may be middle aged, having shifted into psychiatry from a different medical field or having had a previous, non-medical career altogether. Postgraduate fellowship is a different experience for young adults than for middle-aged adults, and each group faces different developmental tasks.

Young adults, for example, may find the transition from studenthood to work life challenging. Not only must you continue to learn medicine and psychiatry, but now the responsibilities of patient care are added. Long hours, sleep deprivation that accompanies being on call, a heavy work volume at a fast pace- all of these factors together stretch the emotional reserves of anyone.

Residents and interns who are single may feel torn between fulfilling their professional duties and their desire for an active social life in pursuit of an intimate relationship and life partner. And those who already have partners may be having and raising children. Some marriages experience significant strain during training. The joys of pregnancy often feel overshadowed during residency even if you are able to arrange a reduced workload and schedule. When spouses and partners are also pursuing careers, intimate and relaxed family time may be at a premium.

Gay, lesbian, and bisexual postgraduate fellows have been welcomed into the Yale Department of Psychiatry for decades. They face all of these same developmental tasks of finding and sustaining an intimate life partner, having/adopting and raising children, and finding time to share life with one's family. They may have postponed some of these milestones because of the added challenges of coming to terms with their sexual orientation. Some homosexual interns and residents may have "come out" and consolidated their identities as gay men and lesbian women prior to their psychiatric training; some may not. Those residents who are still struggling with their sexual orientation may experience added strain during their training.

Middle aged postgraduate fellows are obviously spared the culture shock of the transition from studenthood to entering the work force. They have long been familiar with the commonly conflicting responsibilities of career and family as well as with the necessary juggling of schedules and emotional resources of dual career families. And it is precisely the prior stability and consistency of their family life and routines that are in for a shock during internship and residency. Middle aged fellows may have the added burden of aging parents and all the accompanying economic and emotional strain.

Cultural Differences, Adaption, and Mourning

Fellows who immigrate from one country to another to begin postgraduate training, face all of the aforementioned developmental tasks as well as special challenges arising from their immigration. Whether the immigration is temporary or permanent has a great impact on subsequent adaptation. The losses inherent in a permanent move can be staggering. The immigrant may lose family, friends, mentors, colleagues. A resident may or may not be able to visit or speak with them by phone during training. In most cases, the fellow loses regular use of her own language, often her mother tongue, and supplants it with another. Linguistic difference always complicates adaptation to a new country, but the centrality of language in psychiatry with all its rich complexity and nuance magnifies this problem. The differences of social, religious, and cultural customs and habits, from the mundane to the sublime, may be striking. An intern or resident who has immigrated for psychiatric training, then, will virtually always be in a *state of mourning* in addition to all of the other potential developmental strains already mentioned. For the temporary immigrant, a second state of mourning may occur near the end of training, as you leave the institution and nation where you were "born" as a psychiatrist and face a changed relationship to your homeland.

The Possibility of Serious Psychiatric Illness

Psychiatric residents and interns are not immune to serious psychiatric disorder. Some types of problems present more definitive indications for consultation and treatment. A personal history of serious psychiatric illness, treated or untreated, is certainly a clear indication for consultation early in your training. These conditions would include any history of psychotic symptoms, of depressive illness, of bipolar or manic-depressive disorder, or of alcohol or drug dependency. Significant traumatic experience at any time during your life should also prompt professional consultation. Experiences of incest, sexual molestation or overstimulation, or threats of or actual physical violence during childhood make psychiatric interns and residents especially vulnerable to the reactivation of these catastrophic traumas when you have to evaluate and treat patients with similar histories. Such serious childhood trauma can have several different sequelae in adulthood. One of these is the danger of sexual seduction by, or of, such patients, or the violation of other professional boundaries referred to earlier in this guide. These risks may be substantial and are the strongest indicators for early consultation and treatment.

Less Serious Difficulties

While we have addressed the possibility of more serious psychiatric illnesses during training, residents and interns may also experience less severe though no less personally significant emotional difficulties that could benefit from individual psychotherapy. These troubles may or may not be directly related to psychiatric training. These include such problems as frequent states of tension, apprehension, or worry. You may find it hard to get through the day, as though you are surmounting one obstacle after another, and that work feels like you are just going through the motions. Perhaps you feel tired all the time even when you get adequate sleep and are not physically ill. Or maybe you are unable *ever* to get a restful night of sleep and awake feeling refreshed, even on weekends or on vacation. You may feel that your situation is hopeless and could never get better, that you don't have any friends and are alone in the world, that your zest for life is gone. Maybe you have noticed yourself wanting to eat or drink excessively when you feel nervous or discouraged, that you gain or lose weight when you don't want to. Or you find that you have lost any desire for sex, or that you need sex frequently but are unable to enjoy it or feel passionate with your partner. You might find it difficult to become and stay sexually aroused. Perhaps you feel irritable all the time and fly off the handle easily; or similarly, that you often feel sad and cry at the least provocation. Maybe you cannot allow yourself to work at your full potential. Perhaps you find that you always fail on important projects just before the finish line, that you procrastinate and never finish things, or that you repeatedly shoot yourself in the foot at work or in personal relationships. All of these are examples of milder forms of emotional difficulties that can improve dramatically in psychotherapy.

Getting Help or "Toughing it Out"- How to Decide

We have reviewed some of the stresses and strains inherent in psychiatric training, various developmental and cultural vulnerabilities, the possibility of serious psychiatric illness, as well as less severe emotional difficulties that postgraduate fellows may bring with them. How much personal distress is too much? How do you decide whether and when to seek treatment? Our advice is simple: if you are feeling enough emotional pain or distress to wonder about treatment for yourself, why not seek professional consultation? A consultation is a series of conversations with a mental health professional- a psychiatrist, a psychologist, or a clinical social worker. During these meetings you will have an opportunity to talk with your consultant in depth and detail about your current difficulties and what led to your seeking a consultation at this time. You will also be able to review your history of these difficulties as well as of previous treatment (if any) for these or other problems. You will also have the chance to speak about yourself more broadly. A variety of relevant topics might be discussed to give the consultant a sense of who you are as a person. Such topics as your family of origin and your growing up years, where you are from, significant friendships and relationships, religious beliefs, work life, sexuality, avocational interests and talents- all of these subjects and others might be discussed in the consultation.

After having the opportunity to discuss these matters fully and in depth, you and your consultant can then decide together if the difficulties you describe merit treatment or not. Deciding to enter treatment is a deeply personal matter that may involve many different private concerns. This is why the discussions with your consultant are confidential. No one is privy to what you talk about in these conversations- not faculty, not family, not friends, not colleagues- unless you divulge the information yourself. The faculty wants to be clear on this point. We support your decision to seek consultation or to enter treatment if that is what you choose. We understand the initiative, self-regard, and maturity involved in such a step and respect the importance of absolute confidentiality of this endeavor. In line with this philosophy, we strongly advise against "toughing it out". If you are in any enduring emotional discomfort, we encourage you to seek consultation. Then, you and your consultant can decide what to do from there.

Reluctance to Consider Professional Consultation: Social Stigma

Some residents and interns are reluctant to consider a professional consultation because of the social stigma they perceive or experience related to issues of mental health or emotional difficulty. Many residents worry that seeking a consultation or treatment is a sign of personal weakness or will somehow professionally disqualify them from psychiatric training. Neither is true, but given these biases, that may be difficult to recognize. Despite your field of vocational interest, psychiatric residents and interns are not exempt from the effects of such stigma. These concerns often derive from powerful

experiences in our past in which derisive, demeaning, or devaluing attitudes towards mental illness, emotional suffering, and their treatment were expressed by or towards someone of special significance in our lives. Such experiences may intensify your difficulty in considering professional consultation and might be beneficially discussed with your consultant.

Financial Concerns

Other postgraduate fellows may balk at the prospect of a consultation because of worries about the financial cost. Many residents and interns begin training with enormous debt acquired from borrowing the cost of their undergraduate and medical education. Repayment of these debts usually commences after graduation from medical school. After paying for housing, transportation, and other basic costs of living- in addition to school loans- there is often little surplus left in fellowship salaries. The added costs of a family make financial resources even thinner. The faculty recognizes that professional consultation and treatment are real expenses that may confront real budgetary constraints.

The Office of Education in the Department keeps an updated list of faculty clinicians who have agreed to treat postgraduate fellows at affordable fees. A frank discussion of your financial resources with your consultant is important in arriving at a mutually agreeable fee. This discussion should occur at or before the first face to face consultation. In those instances where you cannot negotiate an affordable fee, special arrangements will be made to ensure that you get needed consultation and treatment. In such a case you should speak with the Chair of the Clinical Faculty Liaison Committee.

For some fellows, "moonlighting" may be a way to afford the consultation and/or treatment. Sometimes, however, financial resources are stretched thin even with moonlighting jobs which can in themselves add to work-related stress (working even longer hours, more sleep deprivation, more time away from family). Although it may feel awkward, asking for financial help from your family can be a solution.

The realities of scarce financial resources notwithstanding, the concern about the monetary "bottom line" may be more complicated than it at first appears. If your physical health and well-being were in jeopardy, for example, would you feel the same reluctance towards medical consultation based on whether you could afford the cost? In the face of serious physical illness, we usually pursue the best possible treatment whatever the cost. What prevents us from having the same attitude about obtaining treatment for serious emotional problems? If the difficulty is not life-threatening, however, similar conflicts that gave rise to the social stigma associated with psychiatric treatment that we just mentioned may also generate, figuratively and literally, *devaluing* attitudes about the worth and value- both personal and financial- of such treatment. Further, there can be a convergence of internalized social stigma deriving from conflicts in your past *and* actual, current discrimination by the insurance industry against its subscribers who seek treatment for mental illness or emotional suffering. This real prejudice against psychiatric treatment, so commonly observed in the current "managed

care" climate, can serve as a powerful reinforcement to irrational conflicts about considering your own treatment.

Talking with Friends and Family

Some postgraduate fellows unwisely avoid consideration of professional consultation by preferring to talk about their problems with friends, spouses, and life partners. What could be more natural than to talk about everyday problems of living with the people to whom you feel the closest? But if the problems involve emotional illness or suffering, that is another story. It may take awhile to grasp fully the fundamental differences between the emotional support and opportunities for growth that a friendship can offer and the emotional and psychological work offered in psychotherapy. Friends, family, spouses, and partners are simply too personally involved with you to make treatment possible. The impact of affectively powerful, personal disclosures- often necessary in treatment- on the relationship can be a difficult issue. Not only would you have to worry about how *you* feel about what you reveal, but you would also be concerned about how your friend, spouse, or partner would react. Most friends, even though personally sympathetic and supportive, are not professionally trained to be clinically helpful when emotionally charged disclosures are made. Distinguishing and maintaining professional and personal boundaries in our clinical work are crucial principles to learn during your psychiatric training. Talk with friends and family by all means, but be prepared to hear that your problems need outside, professional help.

When a Friend or Colleague is Troubled

It may happen during your internship and residency that you become aware of a friend and colleague who seems to be in emotional distress and is taking no apparent steps to seek help. Perhaps you have noticed a pattern of drug or alcohol abuse, signs of depressive illness like persistent sadness, irritability, social withdrawal, or suicidal ideation, episodes of dissociation, including periods of "spacing out", confusion, or disorientation, or evidence of severe relationship problems involving emotional or physical abuse or repeated, volatile breaks-ups and reconciliations. Sometimes a colleague will confide in you about a problem; at other times you may observe or sense it without your friend ever mentioning it. How would you handle such a situation?

Since these issues can be ethically and professionally complex, you should not handle them alone. We urge you to bring your concerns to the attention of the Residency Training Director or another member of the full-time faculty. Then there can be a discussion about how to proceed and whether it is necessary for the Training Director or faculty member to know the name of the person for whom you have become concerned and whether further action is needed. The latter might seem necessary when the stakes are high: when the risk of harm to herself or others seems worrisome, when your friend is suicidal or very seriously depressed, if she is placing the lives of her patients at risk

because of an addiction or manic episode that interferes with her clinical judgment, or if she has become sexually involved with a patient.

How to Choose a Consultant

Once you have decided to seek professional consultation, how do you decide whom to see? The Office of Education in the Department of Psychiatry keeps an updated list of faculty clinicians who have agreed in advance to consult with and treat postgraduate fellows at affordable fees. Refer to the section of this guide entitled "Financial Concerns" for the details of this arrangement. Review the clinicians on this list with a trusted teacher, mentor, supervisor, or friend, and obtain the names and telephone numbers of one or more possible consultants. Call up the consultant and tell her that you would like a consultation to consider beginning treatment. Ask the consultant if she has time available both for initial consultations *and* for ongoing treatment if it proves indicated. During the consultation, not only will you be talking about yourself, but it is also important to assess how you feel sitting with this particular consultant. Of course, the context of this conversation may well intensify any existing anxiety or tension, but in general, you should feel *relatively* comfortable talking with your consultant. If you do not, speak about this during the consultation and discuss the possibility of seeing another consultant so that you can compare how you feel with each of them. At some point during the initial consultation, ask about the fee. Inquire directly whether the consultant can be flexible in setting the fee based on her agreement with the Department and also based on your financial situation; which you should openly discuss. Ask about scheduling future appointments and try to get a sense of whether your schedules will permit you to have a regular meeting time with your consultant. The clinical realities of ward life may require some give and take on scheduling, but eventually the resident's treatment should be accommodated. Some people meet with a few consultants once or twice and then choose among them based on how the consultation felt. Others prefer to have a more extended consultation and decide during it whether to continue with this particular consultant. Occasionally, a consultant may recommend someone else who, by reason of specialized clinical experience, or other related factors, may be a more appropriate clinician for you. The important thing, of course, is to see *someone* for an adequate consultation.

Conclusion

The faculty wants your internship and residency to be an outstanding learning experience that will help you become a caring and competent psychiatrist who will make significant contributions to our field. We are interested in your personal growth and development and concerned about your emotional well-being during your training. This is why we have taken the time to prepare and distribute this guide. We welcome your comments about the guide itself or any issues that it raises for you.

Resources

The Office of Resident Education
maintains an updated list of clinicians who are willing
to treat postgraduate fellows at affordable fees: 203-785-2095

Director of Residency Training: Robert M. Rohrbaugh, M.D.
robert.rohrbaugh@yale.edu, 203-737-2433

Chair, Clinical Faculty Liaison Committee: Stephen Atkins, M.D.
stephen.atkins@yale.edu, 203-782-0044

Yale University Employee Benefits:
http://www.yale.edu/hronline/benefits/pda.html