A Career in Forensic Psychiatry: The Ultimate Unconscious Resistance?

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I never really believed in the idea of unconscious resistance in psychotherapy. For the four years of my training in a predominantly psychoanalytic residency program, I tried my best to understand the basic tenets of psychodynamic therapy, but none of it came easily to me. When I was growing up, my family never talked about feelings. In fact, we never talked about anything other than rational thoughts and practical obstacles; to do otherwise would have been unthinkable in our community of industrious Asian immigrants. Feelings were just not important where I came from, and, even after several years of residency training, psychodynamic thinking was still foreign to me.

Like most psychiatry residents, I saw outpatients in a hospital clinic, and I had little choice about which patients were referred to me. During the winter of my third year of residency, I was assigned the case of Annie (not her real name, of course, but similar to the anglicized nickname she preferred to be called), a young Asian-American woman who was being discharged from the inpatient psychiatric unit after a suicide attempt. It was my task to provide follow-up outpatient care—whatever that meant. As I walked out to the waiting room at 8 a.m. on a Monday morning, I secretly prayed that she wouldn't show up, both because I needed the time to catch up on paperwork and because I already felt overburdened by my patients. It was the dead of winter, and morale was low. However, as I spotted Annie standing at the front desk, it was clear that she was not my usual low-functioning, disadvantaged patient with a severe psychiatric disorder. She was an artistic-appearing young woman dressed in a stylish green wool coat and jaunty hat who was making pleasant conversation with the receptionist. Patients like this didn't come around every day in our clinic, and I was intrigued.

During our first few meetings, Annie gave me a rough sketch of her life. She had been born in Asia and while still a toddler had moved with her family to our city, where she had lived ever since. As a young child, her parents asked a lot of her: take care of her younger siblings, cook dinner for the family, and get perfect grades in school. She had earned both her bachelor's and graduate degrees at a distinguished university, and she had gone on to work in one of the top firms in her field. She had married the man her mother suggested would be a good match, and they had bought a house close to her parents soon after the wedding. A year later, she gave birth to twins. For any Asian family—for any family at all—Annie was a model child.

I learned early on that Annie was unhappy in her marriage and that this unhappiness had been the main precipitant of her suicide attempt. She complained that her husband was extremely demanding and unpredictable in his moods, and his behavior filled her with a mixture of anger and fear. Still, she said that she loved him, and she was deeply ashamed of the suicide attempt and subsequent hospitalization. It quickly became evident that she was also ashamed of being in psychotherapy, as she saw it as a sign of weakness and disease. She was obsessed with

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whether she was "making progress" and "meeting the goals of therapy." I often felt as if she were asking me to measure her against the doorjamb of my office to see if she had "grown" that week. I was sympathetic to her plight, as I could imagine that the nebulous world of psychodynamic therapy was hard to navigate without clear indicators of progress or movement. I could also imagine how being treated for mental health problems would feel like a shock to her system, as certainly the role of psychiatric patient wasn't part of the life plan of someone so accomplished. In retrospect, I should have known that Annie was growing weary of therapy almost as soon as it had begun; any experienced therapist would have seen the writing on the wall. I, however, was not an experienced therapist.

I had been working with Annie for almost a year when she started canceling appointments and insisting that she could see me only once every other week. She talked about barriers to attending therapy in terms of schedules and finances, and I desperately wanted to believe her. She was, after all, the mother of toddlers and working full-time. How could I argue against such demands? In the back of my mind, I knew that we were at a difficult point in the therapy, but I thought that I was being insensitive to Annie's practical concerns by insisting that there was "something else" going on. When I discussed the case with my supervisor, I found myself annoyed at how obtuse and elitist she was being when she started to wax eloquent about unconscious resistance. I mean, seriously, resistance?!! Wasn't that just some concept invented by 19th-century psychiatrists to absolve themselves of blame when their patients didn't get better? Weren't "expensive" and "glacially paced" much higher than "resistance" on the list of reasons not to go to therapy? Clearly, Annie wasn't coming to therapy anymore because it was a hassle. End of story.

That's why I was so surprised by what turned out to be my last meeting with Annie. She came in that day with questions about the limits of confidentiality in therapy: "If I tell you something, does it go in my chart? Do you tell anyone else? Under what circumstances are you required to tell the government about what I said?" Not knowing her to be paranoid, I wasn't sure what to make of her questions. We talked about confidentiality for a bit, and then she told me what she had wanted to say all along—that her husband had hit her last week. And that this was not the first time. And that her toddlers had witnessed these events. And that she was worried that the Department of Social Services might take them away from her because of it. "Oh, boy," I thought as I tried desperately to keep my cool.

I had never seen tears like the ones Annie produced that day. They were seemingly endless (she went through a box and a half of tissues), and both of us were powerless to stop them. She said things like, "How could this happen to me? I mean, I'm a college graduate, and I come from a good family, and I never saw this coming. How is it possible that you and I are sitting here talking about domestic violence?" I shared her disbelief: how was it possible? None of our year-long work had prepared me for this kind of revelation, and I was overwhelmed with emotion. I didn't know what to do or how to feel. And so, as my immigrant parents had taught me all my life, I tried to think rationally about what needed to be done. I thought about whom to call for advice, what resources were available to Annie, and when our next appointment should be. I also tried my best to convey to her that therapy was a safe place for us—the only two people in the world who knew how much she was suffering—to acknowledge the situation she was in. I didn't know what we would do next, but I hoped we could handle at least that much.

Annie left my office that day saying that she would see me the next week and that we would meet together with someone from the hospital's domestic violence program. I never saw her again. She left me a message a few days later with an elaborate explanation of the change in her work schedule that prevented her from coming to therapy for the foreseeable future. When I told my supervisor about it, she said, "Oh, Reena, I was so hopeful that she would come back. I really thought that she would." But, honestly, I wasn't as surprised as I pretended to be to my supervisor that day. I knew almost nothing about therapy and even less about domestic violence, but I did have a sense of the magnitude of Annie's shame about the situation and unwillingness to face it. If Annie were to leave her marriage, it would require more than just a dramatic moment of revelation, and she didn't seem ready for the long and slow extraction it was likely to entail. Instead, she had chosen the less threatening option: to extract herself from the therapy.

Over the next few weeks, I had many conversations with supervisors and colleagues about unconscious resistance, suitability for psychotherapy, and

several other things we think of when our patients leave us for reasons that we don't really understand. Eventually, I came to accept a patient's ending treatment as an inevitable part of any psychiatrist's training. I even constructed a narrative that explained Annie's departure with all of the clarity and simplicity I could muster: she left because her feelings about her marriage were just too painful to face. My colleagues concurred with this assessment, and I began to put the episode behind me.

I was content to leave it at that for a long time. Months went by when I didn't think much about Annie, as I was busy with the end of my residency and the transition to fellowship. It wasn't until I was discussing this case with a new supervisor just a few weeks ago that the pot began to get stirred again. As we talked about what had happened, my supervisor asked me whether it was possible that I had had a hand in ending the therapy with Annie. I didn't want to believe it, but as I thought about it more, I knew that my understanding of resistance (which by this point I had come to regard as a symbol of all I had learned in residency) was a little bit too simplistic. In fact, I had so convinced myself that the narrative was as I told it—that Annie's unconscious resistance to therapeutic intervention had caused her to terminate the treatment—that I hadn't made room for other possible explanations of what had happened between us. I just hadn't thought about the question, "What did I do that made her leave?"

Well, that isn't exactly true. Of course I had engaged in the usual monologue of self-doubt that follows the loss of any patient: "I'm a terrible therapist. . .a better psychiatrist would have prevented this from happening. . . . If only I had said X or Y. . . ." That wasn't the point. What I had neglected to do was to think about the situation in a more nuanced way and incorporate the possibility of my own resistance into the mix. How could it have escaped my attention that, at the very moment that Annie was telling me about her marital problems with her parentally approved husband, my own life was at an important crossroads?

My parents had long been encouraging me to meet a "nice Indian boy," preferably a fellow physician who was my equal in all the ways they considered important: education, ethnicity, and socioeconomic class. I had resisted this advice for as long as I could, but, as I entered my late 20s, I began to wonder if perhaps they were onto something. I wouldn't say that it was in the forefront of my mind, but somewhere inside of me was the nagging thought that my life might be happier if I were to settle down with a "demographically appropriate" man. When Annie came into my life, I didn't consciously think about her as a reflection of the life my parents were advocating. It escaped my attention that she was eerily similar to me: about the same age, from an Asian background, overachieving, introspective, and working in an atypical field for Asians. And so, when Annie told me during that fateful last meeting about the profound unhappiness she felt in her marriage, I felt compassion for her, but I didn't think her suffering had much to do with me personally.

In retrospect, Annie's story really did hit close to home. When I was with her, I felt as if I were standing at a fork in the road, looking down the path my family had always labeled the "correct" one, and seeing the potential horrors that lay ahead. Although I behaved professionally and found the words to say, "It's okay to tell me about this," I was perhaps speaking with my hands covering my ears and my eyes tightly shut. Some patients can sense this reluctance in a therapist; I'll never know if Annie was one of them.

My work with Annie has been, without a doubt, a great learning experience, and I am forever indebted to her for teaching me so much. One of the most humbling things I've learned is that even this new narrative—the one about my family and my own unconscious resistance—is just one of a million possible explanations of what happened. What if it wasn't about my family at all? What if Annie simply sensed that I was overwhelmed by her revelation and felt that I couldn't help her? What if she had planned to leave therapy even before that day, and the revelation was a "parting gift" to me? What if she was able to tell me those things because she trusted and felt close to me, and that closeness overwhelmed her? The possibilities are endless, and I could spend a lifetime trying to think of them all.

Before I began the most recent chapter in my life, a fellowship in forensic psychiatry, I attempted to file this story away under "Lessons Learned" and forget about it. However, as I make the transition from general psychiatry resident to forensic fellow, the ghost of Annie still haunts me. She plagues me with thoughts like, "What are you doing? You worked so hard to learn this psychodynamic stuff, and now you're just throwing it away to do risk assessments

and competency evaluations?!!" Annie raises an important question. Forensic psychiatry is (arguably) the most objective, almost business-like subspecialty of psychiatry, and in many ways I couldn't get any further away from psychodynamic work if I tried. As I look back on my decision to pursue this line of work in the aftermath of treating Annie, I can't help but wonder, "Am I choosing forensics out of a desire to avoid experiencing the powerful feelings I had as a therapist? Have I managed to find my way to another community in which everyone is engaged in the pretense that the world is rational and logical? Is my career choice just some elaborate resistance to personal growth?"

Forensic work is difficult. It poses the unique challenge to the psychiatrist of fulfilling multiple roles—compassionate physician, truth-teller, performance artist—that frequently conflict with one another. Furthermore, the stories we hear from our patients are simply horrific. They force us to confront the worst aspects of humanity, and we are often left with the lonely task of managing the intense, contradictory feelings that arise during the course of our work. Even though we have all developed personalized coping mechanisms—talking to friends and colleagues, balancing forensic cases with other types of work, drinking to excess—the struggle is ongoing. It's only natural that we are constantly searching for a strategy that will lessen the emotional burden of the work we do.

As physicians, we all learned that ignoring our emotions is one way to manage them, at least temporarily, to "get the job done." I understand the wisdom of such an approach in some medical specialties, but I worry when I see it applied to forensic psychiatry. There are members of our profession who believe that forensic psychiatry is science, pure and simple, and that feeling therefore has no role in its practice. This can't be true, can it? Aren't we doing ourselves and our patients a disservice by ignoring that which is subtle, subjective, and intangible? My psychodynamic training tells me that those who assert that there is no role for emotion in forensic practice are just using the defense mechanisms of denial, isolation of affect, and intellectualization. In addition, they are denying themselves a potentially useful clinical tool that can actually enhance the ability to perform forensic evaluations. I would be content to smile knowingly to myself about these insights, but I am troubled when I see the notion being propagated to my generation of trainees that the goal of forensic psychiatry is to produce certainty.

On one of my fellowship interviews, a prominent forensic psychiatrist perfectly captured this intolerance of uncertainty and feeling by asking me for my opinion about a case and then reminding me, "There's a special place in hell for fence-sitters, Reena." I understand his point. Forensic reports inherently answer questions "yes" or "no" because that's what the legal system demands, but I'm not sure that all of this emphasis on objectivity and precision is anything more than an attempt to manufacture certainty where, in fact, none can be found. That same forensic psychiatrist also once said, "Forensic psychiatrists do not feel. They opine." Although I know he was just making a point about the semantics of a forensic report, I was struck by the potential broader interpretation of the comment. It left me wondering what happens to me if I do feel, if I can't turn off that part of myself, or if I choose not to. Am I just not cut out for this work?

To be fair, I should acknowledge that my characterization of forensic psychiatry as devoid of feeling is an overly simplistic one, and there are many people in the field who have written elegant treatises on the topic of empathy and compassion in forensic work. Countless psychiatrists have found their way from psychoanalysis to forensics, and I'm sure that they could easily tell me the ways in which an understanding of psychodynamic theory enhances their practice. I really don't mean to castigate the field or imply that I am the first to navigate these choppy waters. I am simply trying to outline the challenge for my early career as I see it: to integrate the values I learned growing up, the hard-earned emotional lessons learned in residency from patients like Annie, and this new emphasis on certainty and precision in my fellowship training into an approach to forensic work that is authentically mine.

Getting back to my question about the role of unconscious resistance in my career choice, I doubt that I will ever know whether my move to forensic psychiatry is a way of resisting the kind of painful personal growth that came from my work with Annie. That's the trouble with unconscious resistance, right? It's unconscious, so no amount of reflection and reasoning will ever uncover the "Truth." The best I can hope for is to join a community of thoughtful, compassionate forensic psychiatrists who are committed, as I am, to exploring and embracing the

complexities of the work we do. I have been fortunate to find some of those people in my fellowship training, and I hope to meet many more as my professional circles enlarge. For now, I am content to sit with what my psychoanalytic colleagues might call "deep ambivalence" about whether psychodynamic thinking has a role in my forensic career. From my new vantage point at the interface of law and psychiatry, I suppose it would be said more succinctly: the jury is still out.