



Reflections from a Psychiatric Hospital in Rwanda

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“How long will I have to be on these medications?” It was my first day rotating through the largest neuropsychiatric hospital in Rwanda. I was meeting with one of my preceptor’s patients as part of a psychiatric consult: Gloria (name changed for confidentiality), a 29-year-old woman with a diagnosis of schizoaffective disorder. I empathized with her question and imagined the emotion behind it—the sometimes relieving and sometimes constricting feelings that come with a diagnosis, and the stigmatized thought, whether cultural or self-imposed, of suddenly being tied to “relying on medication to be myself.”

I did my best to answer, being transparent around the fact that I was still learning, and I offered the framework I had learned thus far in medical school—schizoaffective disorder being a diagnosis that oftentimes requires staying on medications long-term to prevent relapse. Then, my mind suddenly jumped: “Is this how I’ll be responding to a patient like this ten years from now?” With innovations rapidly changing the field of psychiatry, perhaps other remedies might soon be available. I recommended that she should check in with her psychiatrist regularly regarding medication dose changes, and that her treatment options were not necessarily set-in-stone.

Gloria was solemn, occasionally looking down, and suddenly more questions arose:

“What even caused my disease?” Tears began to streak down her face as she continued her questions: “Do you think it has to do with the fact that my father sexually abused me when I was younger?” I thanked her for feeling comfortable enough to trust me with such sensitive information. I was not sure what else to say at first besides, “I’m so sorry.” I felt I was being pushed out of my comfort zone, grappling with the fact that I am still learning the best ways to respond to descriptions of childhood trauma, especially in

a cultural space much different than my own, sensitive to maintaining ethical boundaries and my own cultural humility. I wondered, “why was I – a medical student from another country – someone she trusted enough to tell this to in the first place?”

We talked for some time about how difficult experiences and abuse can contribute to psychiatric disease. We also discussed how relationships, genetics, and the often-underappreciated social determinants of health can add up to create what we experience as our *mental health*. This is the gray space of psychiatry, the space that drew me to the field in the first place—my philosophical, creative, and less algorithmic side. Yet, this is also the space that I fear will be unknowable; how did the complexities in this patient’s life contribute to her illness? Will I be left wondering if the care I offer to my future patients is creating a lasting, positive impact in their lives?

My mind jumped again: “What about all the other life experiences and complexities that may have contributed to her disease – how else might we treat these from a psychiatric vantage point?” I sometimes fear becoming a psychiatrist will translate into being mostly the “drug guy.” Although I appreciate the huge role medications can play for many individuals working through mental health difficulties, I view them as one tool among many that can contribute to mental health. I hope to appreciate and stay curious about the multitude of supports and remedies that exist throughout that gray space—to incorporate therapy, to reframe ideas, to find the time with patients to dive into their habits, relationships, and thought processes that might be contributing to their condition, to know when to refer and ask for help, and to consider alternative therapies.

But I am concerned that the system will not always support those endeavors. From financial incentives to packed patient schedules, I wonder how difficult it will be to give each patient the comprehensive treatment they deserve. And then, I think of some of my mentors in psychiatry and medicine that have been able to accomplish this—being intentional and flexible in their career trajectories, some creating

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their own structures of practice, others diving into community movements and upstream interventions, while still carving time to maintain their authentic selves and their variety of passions and hobbies. They give me hope.

Gloria and I spent some time discussing the possibility of psychotherapy. She expressed openness to the idea while also educating me on some of her personal barriers to doing so. As our time together wrapped up, we thanked each other, both glimpsing hope in her future. I left that day wishing I could continue to work with Gloria. Given the nature of medical school rotations and short-term therapeutic relationships, I was only getting a peek into a tiny snapshot of this human's life. It leaves me excited for the privileged opportunity to be a continuous guide in patients' lives as a future psychiatrist, and to have the chance to see their conditions improve.

Over the course of my moto-taxi commute home through the streets of Kigali, questions continued to pop up in my mind: "What are other ways psychiatrists might be able to address mental health issues before they become pathologic?" I remembered the impressive strides Rwanda is

making to address mental health upstream, like the Trust Based Relational Intervention, a trauma-informed approach in a secondary school setting that I had the privilege of engaging with just a few weeks before.

I arrived home feeling grateful for a challenging learning experience that pushed me to consider the similarities and differences between addressing mental health in two different countries. I remain hopeful for the opportunity to be a psychiatrist, and the privilege, humility, and great responsibility that comes with it.

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