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Throwing Jello: A Primer on Helping Patients

Edmund G. Howe

Edmund G. Howe, MD, PhD, is a Professor of Psychiatry and the Director of Programs in Medical Ethics at the Uniformed Services University of the Health Sciences in Bethesda, Maryland; and is Editor in Chief of *The Journal of Clinical Ethics*. © 2006, *The Journal of Clinical Ethics*. All rights reserved.

In this issue of *The Journal of Clinical Ethics*, a case from the Harvard Ethics Consortium discusses a patient named Lorraine who sometimes was so violent she drove careproviders from her room. Such situations are not uncommon, and the outcomes often are tragic. In this case, Lorraine eventually stopped treatment, suffered greatly, and died of infection from her decubitus ulcers.

In situations like this, staff are often split: some side with the patient and others side against. The latter may come to feel contempt for the patient, and, if they do, the situation typically worsens. The patient can feel increasingly alone, and become more aggressive, maybe because isolation is the most painful of all feelings. Staff may then feel even more helpless and enraged, and the vicious cycle intensifies.

This is apparently what happened with Lorraine. As Jennifer Repper-DeLisi and Susan M. Kilroy write in “‘We Need To Meet,’” the staff’s “natural responses” to the patient were “frustration, anger, and rejection.” Staff usually try to do the best they can, as in Lorraine’s case, but we may not help patients as much as we hope. In reality, it may not be possible to help them — for example, in this case it is unlikely that Lorraine could have done better. But there are exceptional approaches that can be used when conventional approaches don’t succeed. These approaches may help all patients, but, with patients like Lorraine, they may be lifesaving, so ethics consultants and other careproviders should at least know about them.

PRELIMINARY CONSIDERATIONS

WHY WOULD A PATIENT ACT THIS WAY?

The approaches I’ll describe can be used with any patients with whom we find it difficult to relate. Patients who become angry, as Lorraine did, pose greater problems when they express anger, which can evoke fear. We all are at greater risk of becoming inappropriately angry when we are ill — or even just feeling stressed. Some people, however, habitually become inappropriately angry, and this is one hallmark of those who have borderline personality disorder.¹ Therefore, I will use this disorder as a paradigm for understanding patients like Lorraine.

The mood swings of people with this disorder are, characteristically, “stably unstable” — their moods are fragile, but the state of fragility is static.² Persons with this disorder are calm one minute and may feel enraged the next. As one clinician describes it, “The slightest perception of condemnation may result in a strong and unpredictable violent response.”³ Why?

One way to understand this behavior is that people with the disorder have great difficulty sustaining the feeling that they are "okay," and that almost any input can trigger a belief that they aren't okay. When the patient's mood plummets, she or he may feel worthless, and that may be unbearable. The patient's mind may immediately and unconsciously try to relieve this feeling by replacing it with another that is less painful. The "replacement feeling" might be fear, and the patient may become paranoid. Another feeling that may replace worthlessness is anger, because, for many people, it is less painful to feel anger. But, in the long run, anger may be worse for the patient, because it can frighten other people away, and the isolation that results may be more than the patient can stand.

The implication for careproviders is critical: they must avoid triggering patients' feelings that they aren't "okay." Recent advances in brain imaging provide additional support: they indicate that, physiologically, persons with this disorder may experience inappropriate and overly intense anger for two reasons. First, the parts of their brains that trigger aggression may be too sensitive, and their anger centers may be too easily triggered and "fire off." Second, the other parts of their brains whose "job it is" to inhibit this response may under-function.⁴

In any event, the result is the same. The "nerves for aggression" fire, and the patient "explodes." The aggressive behavior is virtually automatic.

One implication is the one just considered: careproviders should avoid inadvertently triggering patients' angry responses. A second implication is less self-evident: patients may be overly aggressive for another reason. They might intentionally be aggressive for personal gain.⁵ This may be not because they are impaired, but because they choose to be aggressive. Such behavior is willful as well as exploitative.

Therefore, careproviders who want to help patients like Lorraine may feel they are in a bind. They can't know whether a patient's anger is fundamentally involuntary, and so is outside the patient's control, or is intentional — or maybe is both. Further, it's natural to assume such behavior is intentional, and to act in a way to best protect ourselves.

But if we do, it may cripple our efforts to help. If we misunderstood, patients may feel wronged and even betrayed. An example is when we respond to a patient who becomes angry and demanding and we reflexively set limits that are inappropriately strict. The patient may see these limits as arbitrary and lose trust in us.

WHAT SHOULD BE AVOIDED?

It's ideal for careproviders to not respond with inappropriately strict limits, but patients do test the limits set for them. This may be one of their underlying problems. As one careprovider noted, "Many of the most desperate patients refuse to play by our rules."⁶ We may need to alter our usual limit-setting practices or risk failure with these patients. As another careprovider suggested, "Excessive technical rigidity limits receptivity to the client's style of problem solving."⁷ What should we do instead? There are three ground rules. The first is the most important.

1. Allow others to set limits, while we help patients pursue their interests until the limits that are set are absolutely necessary. Stated another way: we should ally ourselves wholly with patients' needs and pursue meeting them as vigorously as we would our own.⁸ This is the key. To any degree that we compromise our commitment to patients' interests, we lose the capacity to help.⁹ Other parties can and will, in time, set limits, and we can pursue patients' interests until this happens.

Here's an example. A father so distrusted surgeons that he would not consent to surgery for his six-year-old daughter unless he could watch while it was being done. He agreed to watch via video hook-up from another room, but the surgeons refused and threatened to go to court. An ethics consultant could have pursued the possibility of a video hook-up, and perhaps also arrange for a careprovider to describe what was being done. The rationale is that patients may not readily accept careproviders as their allies.

The remaining two ground rules are far less demanding, and follow from the first.

2. Careproviders must be wholly willing to ignore their own moral views when they hope to convince a patient that they serve only the patient's interests. This becomes more difficult because careproviders must retain the credibility of their colleagues when they do this.

3. *The third ground rule, therefore, is that careproviders (beforehand, ideally) should explain to colleagues what they will do, their underlying rationale, and why it is not only justifiable, but morally obligatory.* If they don't do this, in extreme cases, a patient may die unnecessarily. The approach of informing others that one will engage in an unusual therapeutic endeavor, and explaining why, has been carried out in other settings. For example, one psychiatrist I knew would routinely alert his colleagues that he wasn't initially going to give patients with schizophrenia who were psychotic antipsychotic medication. He believed that for them to be willing to take medication over the long run, they had to believe, themselves, that they needed it, but that sometimes they would only come to believe this if they could test it out for themselves.

When careproviders help patients to pursue what they believe they need and want, others may establish limits. When this happens, careproviders can say truthfully that they have done all that they can. Even when patients are greatly impaired, they are still likely to be able to fully understand and appreciate that, although their careproviders have some power, they aren't all-powerful. Careproviders should discuss this with patients in advance. It may allow them to remain the patients' allies.

WHAT CAN BE DONE?

To reach patients, above all else, careproviders must form a trusting relationship. If patients can acquire such a relationship with just one careprovider, it may be enough, because the patient will no longer feel alone. If this is possible, the patient may not feel alone, even if the careprovider is away.

When patients are severely impaired, it is easy to see how important it is for them to have a careprovider they feel they can trust. Even when patients are paranoid or floridly psychotic, a trusted careprovider still may be able to "get through" to them, even at the most difficult times. This is because it has been found that, even when patients are mostly out of touch with reality, they still may retain the capacity to respond to others in a normal way.¹⁰

To gain patients' trust, we may need to respond quite differently than we normally might. For example, we usually hold patients accountable when they act inappropriately. With a patient like Lorraine, in the Harvard case in this issue of *JCE*, we might do well to do the opposite. To gain a patient's trust, we might better respond as though we somehow provoked the inappropriate behavior, and ask the patient what *we* did.¹¹ In time, we may be able to be more fully honest with the patient; later, we may even choose to share how we and other staff feel toward the patient — and the feelings that we disclose may even include hate. To do this successfully, however, we must first earn patients' trust.

It is not wholly irrational to respond as if we somehow caused a patient to react as he or she did. As Mary Zanarini and Kenneth Silk, leading authorities on borderline personality disorders, state, "it is hard to imagine a borderline patient bothering to regress on a desert island."¹² That is, patients don't become aggressive when they are alone. If we want to foster a trusting relationship with a patient, we may take this further: should a patient become aggressive, we may choose to respond paradoxically, as some of the careproviders in Lorraine's case did: we may choose to respond by being more caring and loving.

August Aichhorn used this approach when he treated involuntarily committed juvenile delinquents more than a half-century ago.¹³ When, for example, these teenagers "acted badly," he invited them to join him and his wife for a special dinner in their home. Why did he find this approach effective? Above all else, doing this conveyed a feeling of all-overriding and unconditional love. By doing this, Aichhorn conveyed that he could distinguish at all times between what these delinquents did and who they were. He communicated clearly that he never forgot that they were still wholly lovable persons.

These delinquents may, like some patients, "act out" most when they hurt the most. Thus, when Aichhorn invited the delinquents to dinner, it may have also acknowledged his implicit understanding of their unexpressed hurt. We can indicate this too. If we were to bring a favorite meal to a patient like Lorraine after she "acts out," we might say, "I imagine that you may have been angry because you were hurting. Were you?" The key to reaching patients is best conceptualized as follows: we should act, in all circumstances, as if it is our relationship with patients that counts the most with us. For instance, after an ethics consult is finished, no matter what the outcome, our relationship with the patient should be intact.

SPECIFIC STEPS

1. CREATE AN ENVIRONMENT WHERE A PATIENT WILL MEET AND TALK

Getting a Patient to Meet

A patient may be unwilling to meet with careproviders; often this is due, in some way or other, to fear. When this happens, we can try to find ways that the patient will feel safe enough to meet with us. Here are three approaches.

*Offer to go to the patient's home.*¹⁴ Some patients who won't come into the hospital will agree to be seen in their own home, on their "turf." In the patient's home, we are the outsider.

Suggest that the patient invite as many other family or friends as he or she wants, whether the meeting is inside or outside the hospital. The patient may see this as a demonstration of sensitivity to his or her emotional "plight," and it may have a profound positive effect.

This offer implicitly recognizes, and represents an effort to offset, the difference in power between patients and careproviders. If a patient invites others, it may help him or her to feel more secure. Would this cause us to feel intimidated? What if the patient invites 12 loved ones? Would we feel alone or anxious? The answer should be no, and the reason is important — as careproviders, we must be wholly devoted to serving only the patient's interests. If we instead try to facilitate a compromise between the patient and other parties, the patient may lose trust in us, and even feel betrayed. We probably can't meet a patient's needs and also facilitate a resolution between competing parties — even though this might be what we would otherwise usually try to do. So it makes no difference how many loved ones a patient invites to a meeting — we should never have a need to feel defensive, because our only goal is to further the patient's "agenda." If we do feel defensive, it may mean that, at some level, we are acting to further another party's needs. If we have a conflicting agenda, it should be acknowledged from the start. It may cause the patient to reject us altogether. Even if this happens, we have remained honest and forthright, and it may help to keep the relationship intact. Later, the patient may be able to reconsider and request that we again provide care.

Increase a patient's feelings of safety by saying, before meeting, that if the patient feels offended at any time during the meeting, she or he can leave the session immediately — no questions asked. We can also assure the patient that, if she or he does leave, we won't feel angry, but instead appreciate that the patient agreed to meet at all. This provides the patient with an "escape route." With this reassurance, a patient may be willing to meet.

Getting Patients to Talk

If we can meet with a patient and can talk, it may allow a relationship to develop. Some patients, however, may not be willing to talk at all. In this situation, there are exceptional approaches that can be tried. The following approach may serve as a paradigm representing the kind of extra effort that we can make.

Some patients won't speak to careproviders because they are greatly impaired and withdrawn. They may literally be unable to look a careprovider in the eye. They may also find it extremely upsetting to have a careprovider speak directly to them. Since these patients find directness upsetting, we may be able to communicate with them only by looking away or at the floor, or by talking about them in the third person. It is conventionally thought in our society that we should look directly at patients and speak to them, not about them, and to do otherwise is implicitly demeaning. But some patients may not be able to speak to careproviders unless we act in a way that would usually seem demeaning. Why might this work? J.S. Gans notes, "This indirect method should be employed only when direct communication does not enable or facilitate therapeutic work . . . people do not have to be looked at or spoken to directly . . . to feel cared about. . . . With one patient, for example, when the therapist tried to make empathic statements the patient would wince."¹⁵ This approach may assist careproviders. Gans also notes, "The truth is that we sometimes do need temporary, partial insulation. . . . [It can be] reassuring for both. [It communicates to the patient:] Since I know that you are doing the best you can, I will not burden you with expectations sometimes implied by eye contact."¹⁶

Almost all of us would feel helpless and inadequate when caring for a difficult patient like Lorraine. As a defense, we might come to feel very angry. Our jaw may clench when we are with a difficult patient, to the point we are nearly unable to speak. The potential benefits of being "indirect" when interacting with a difficult patient indicates an important point: Some of our difficulties in communicating may come from us.

Finally, the efficacy of speaking indirectly to a patient indicates another fact: to help patients like Lorraine, we may have to go "outside the box," or even against the values of society and the medical profession. Gans notes that talking with patients indirectly "deviates from what is accepted as normal behavior in our culture."¹⁷ Recent data reports that there may be a scientific basis for taking this approach; brain imaging techniques indicate that it may increase the stress of those with autism when others relate with them directly.¹⁸ Perhaps this is also true, to some degree, for patients like Lorraine.

2. ENGAGE PATIENTS

Careproviders must be able to communicate with and engage patients to help them. An important component in communicating with and reaching patients is the first time a patient meets his or her careprovider. If a patient seems upset at the first meeting, what should be done? If a patient is clearly upset and this is not addressed, the patient may find it degrading.¹⁹ After the initial greetings have been made, a careprovider may engage a patient best by asking what is most important to him or her. We can make clear that it is our goal to try to help the patient to get whatever it is he or she wants most — and, over time, we have to deliver on this.

When we ask what a patient wants and explain our priorities before we do anything else, it conveys that what the patient wants is truly our primary concern. The need to be fully the patient's advocate is absolute. Unless we can do this, patients like Lorraine may not trust us. We may feel hesitant, for many reasons. We may feel that this isn't our role, or we may fear being criticized by colleagues, including colleagues who consult us. Regardless, this may be the only way that we can succeed.

Here is how this approach would work, using an extreme case from my own experience. A patient was "using up all of the blood" in the community. An ethics consultant was contacted, and was implicitly expected to help the patient and his family become more open to accepting that, at some time, the blood infusions would have to stop. The consultant worked it through in her head: "There's only so much blood, and other patients need it too. Sooner or later [the patient's] ongoing need for enormous amounts of blood will exhaust the supply. If we allow that to happen, others will die, so it's obvious that this can't go on indefinitely." Although she did not express herself to the patient and family in this way, they seemed to pick up on her dual allegiance. They felt she had come to persuade the patient to give up some days of his life. Rather than accept the reality that others' interests were at stake, they rejected the assistance of the consultant altogether.

The outcome might have been different if the consultant worked it out this way in her head: "I'll help the patient to continue to get blood in any way I can, and be frank about that with him. I'll leave it to others to decide when to say 'No more blood.' My goal is to help him achieve his ends. When it gets to the point that someone else says the infusions have to stop, he may trust me enough to let me continue to help him and his family deal with that news."

How could this same approach be used with a patient like Lorraine who "inappropriately" seeks to die? We could — although it might contradict our own values — side with the patient. How could we do this? We might offer to help the patient "die better." The end result could be paradoxical,²⁰ but obtaining a paradoxical result is not the goal. We should try to further patients' goals, as they see them, primarily because, if we do, patients won't be alone. They will have us as allies, and this may be enough to give patients a reason to live. Battin states this as follows: "there is a third alternative: . . . work with him, not against him, in planning [his suicide]. . . . My guess is that if [the patient] were really offered help in thinking through his plans for suicide in a straight-forward, non-disapproving, non-duplicitous way, he would be much less likely to kill himself, at least not right away."²¹

Patients might misconstrue such an unusual offer, as careproviders don't commonly offer to help patients to die. Patients may suspect that their careprovider wants them to die, but careproviders, by their words

and actions, can convince patients that this isn't the case. The more difficult problem is that patients may suspect that careproviders who offer their help without limits are in some way "setting them up." For example, patients may fear that their careprovider will later use what is said, in some way, against them.

To defuse such fear, careproviders can explicitly acknowledge it. We can say that we can imagine that the patient, on the basis of prior experience, may not trust what a careprovider says, and we can understand that. Further, we can say that, even if this isn't the patient's past experience, it might make sense for the patient not to trust a careprovider, and it might be better for the patient not to try. We can then say that if the patient wants our advice, she or he should trust us only after trust has been earned, and we hope the patient will give us that chance.

How could this approach have been carried out with Lorraine? There are several ways, but this is one. Lorraine had pain, and she wanted greater doses of analgesics. This is one of the most difficult decisions careproviders encounter. The principle of pursuing Lorraine's needs, as she saw them, suggests that her careproviders should have tried to do all they could to give her the relief she sought, whether or not they personally agreed with this goal, and whether or not other careproviders opposed them. They could inform Lorraine that this is what they would do, and they could even say that if other careproviders refused, they would help her to the extent that they would bring her case to court. This might have caused others to give Lorraine greater pain relief, at least temporarily, although it might have killed her. Thus, the result might have been that her careproviders would have given her analgesics or sedative meds until she had sufficient relief to say "enough," or until she was too obtunded to speak, or until she died. This approach is used by some hospices in situations when patients feel "existential" agony and request terminal sedation to gain relief. The patients report they feel agony, not because they are depressed, but because they feel emotional pain that is worse, knowing that they are waiting to die.²²

Some patients who are given brief doses of extra sedative medication under these circumstances respond in the following way. After they have been sedated for a few days, the medications that "obtunded them" are slowly withdrawn, and they respond paradoxically by feeling more "alive." They no longer want terminal sedation for the rest of their lives, but rather cherish the remaining days they have to live. Why this happens is not yet known. It may be that after the patients have found a careprovider who is willing to meet their requests, even for a brief time, they feel more understood. Supported in their request, they may feel that they have an ally. This may be what they need, and indeed long for, more than anything else.

3. RELATE TO OUR OWN FEELINGS

We may presume that difficult patients realize how they affect others, but this may not be the case. This may be presumed because some truths seem self-evident. How could this person *not* know? It may be a great error, however, to attribute this knowledge to patients. For example, patients who attempt suicide may not know — or even imagine — at all accurately how their actions will and won't affect others. They may greatly overestimate or greatly underestimate others' pain. Once they attempt suicide and "fail," they may believe that others are able to respond to them in the same way that they did before. But others may not be able to — their loved ones may always fear that they will try this again.

If we can establish trust with a patient such that he or she can really hear us, we can give the patient accurate feedback about how she or he affects others. This may be critically important information to the patient, and may also have immense, hidden benefits for us, as well. Patients like Lorraine need feedback, first, to know what they are doing "wrong," so that they have the possibility of being able to change. They may want to change, so that they can better get whatever it is that they really most want. We may be able to help a patient by doing what careproviders rarely do: we can tell the patient about our own and other careproviders' negative feelings toward the patient. This feedback, and this alone, may enable the patient to acquire the new skills that he or she needs.

For example, Lorraine may have most needed better control of her anger.²³ After forming a bond of trust with Lorraine, a careprovider could have told her she needed this skill if she wanted to be on better terms with the staff. The real gain from such feedback may be even greater: honest feedback, even when it's

negative, may help patients feel valued. It may affect them so much that they will feel that they are "among the living," rather than as bedridden, or as someone with another impairment who is "just waiting to die."

When we share with patients what we and others feel, it also helps patients to be able to grow. When a patient is abusive, as Lorraine was, we could say, for example, "I feel hurt when you get angry like this. I also feel afraid to come back into your room. Do you understand why you are doing this?"²⁴ This is another way that careproviders can help patients feel that they are "still living," rather than waiting to die. As the above phrasing suggests, we shouldn't presume that patients — or any of us, for that matter — know why they act as we do, because we may not. We can anticipate this and ask patients questions in ways that don't imply that they should know why they act as they do.

Or we could ask other questions that patients are more likely to know the answers to: "Is there something I did that made you feel angry?" Asking in this way lessens the possibility that patients would feel shame, because they don't know why they act as they do. By confronting patients with their own and others' feelings, we can help them accept parts of themselves they feel shame about, such as envy and even hate. As one group of careproviders who did this reported: "By talking about [their] hate, the team helped the patient accept [this] part of herself. . . . Her envy needed to be . . . detoxified. . . . We [made sure that] she did not suffer a loss of human contact . . . [and] repeatedly emphasized our wish to talk to her . . . about these feelings . . . that made her life so difficult."²⁵

We can also ask questions that are more confrontational but also show greater concern: "Is there something you are afraid could happen by working with me?" Since some patients may experience this question as accusatory, however, we can tell the patients our intent before we ask: "I know you have reasons for becoming angry. That is always the case, in some way. But it would help me greatly to understand you if I could know what your reasons are. When you become angry you drive me away. Do you want to? Is there something you are afraid could happen by working with me?"

Finally, we could share our own feelings of helplessness, which may help patients see that it is really they who are in control, and only they can try to bring about a better outcome. In most ways, these patients are helpless. Thus, when we share this information, it conveys a feeling that we may have in common, and "shared helplessness may provide a pathway to empathic connection."²⁶ Sharing in this way may also help to "level the playing field." More than anything else, such unexpected candor may reduce patients' feelings of being isolated, which may be much more painful than anything else.

4. TEACH PATIENTS NEW SKILLS

Once patients like Lorraine are sufficiently engaged to be able to really hear feedback, they may want to change. Even if they don't want to change for the sake of others, they may want to change for themselves. The task, then, is to help patients identify the skills they need, and to help patients find some way to attain them. Lorraine, like other patients who become angry, needed above all else to find a way to control her anger. She may have been able to use a practice called mindfulness,²⁷ which involves learning to distance oneself from one's immediate emotional responses, and then to continually monitor or even "grade" one's responses. This practice can allow us to not only control anger, it may help us bear even great pain.

Patients who work to learn a skill such as this should be told that each time they try, they will get better at it, and that the reason is that each time they try, the connections between the neurons in their brain will become greater.²⁸ Not only is this true, it can be a source of hope. But patients should also be given a "safety net," so that they have an alternative way to control their anger if the approach they are learning fails. They could, for example, acquire 24-hour access to someone, somewhere, whom they could call and talk to. This might, perhaps, be a someone that patients can emotionally accept as a "stand-in" for a careprovider they trust when the careprovider is absent. Patients may find surprisingly great feelings of relief in talking with another person whom they know beforehand is standing in the trusted careprovider's "stead." For example, careproviders' receptionists may fill this role. Although their primary duties may be to arrange schedules or answer phones, in some instances a receptionist's response to patients is as important to the patient as the careprovider's response. When a trusted careprovider can't be reached, receptionists have prevented patients

from committing suicide. Even if a patient never makes any calls, having a "fall-back option" may prevent an outburst. Further, careproviders who arrange for a back-up may convey to patients how much they really care. Even if other interventions don't "get through," this one may.

Some patients may, on the other hand, have more than enough skills to accomplish what they need to do. When this is the case, our task is to help them identify the skills that they already have, so that they can "transfer" these skills to the situations in which they need them. Doing this may be preferable to helping patients acquire new skills for two reasons: first, patients' need to change may have considerable urgency, and, if they have skills already, they may be able to transfer those skills immediately. Second, if patients have the prerequisite skills, this is a ground on which they can feel genuine, greater self-esteem.

How we can help patients to identify and transfer skills that are already present is illustrated in the following case. An inmate had been repeatedly, impulsively violent before coming to prison. If he continued to be violent in prison, he wouldn't gain early parole, which he desperately wanted to do. He realized that he urgently needed to learn to control his anger, which he'd never been able to do before. He told his counselor in prison, "I can't help myself," and he meant it. His counselor said, "Sure you can. Tell me about when you feel angry, but choose not to beat someone up." The inmate replied, "When they have a gun." "Then what do you do?" the counselor asked. "Then, I walk away," the inmate said. The counselor told him that all he needed to do was to imagine that anyone he wanted to fight in prison had a gun, and he would be able to walk away. The prisoner was able to do this, and he earned early parole.

5. RESPOND TO FEELINGS OF COUNTER-TRANSFERENCE

It is essential that careproviders who interact with patients like Lorraine find some way to continue to care for them. When we can't do this, we may be better off not interacting with the patients at all, or possibly we should work in some other field. Sometimes we may care about a patient, but find that we have feelings like hate. When we do, the course we should take is well prescribed: we should first seek out other staff with whom we can share these feelings, if we don't have this outlet already. The staff we seek out must be people we know won't judge us for having such feelings. If this doesn't work, we should seek help from mental health careproviders who have special understanding of how the feelings of careproviders and patients work. They can explain what is otherwise hard to discern, or even imagine. For example, we may learn that some patients may act in a demeaning way because they need their careproviders to reject them.²⁹

Just knowing this may greatly alleviate the intensity of our negative feelings. We may need to know of such possibilities to be able to believe that patients' abusive behavior isn't willful and/or that the underlying fault is actually theirs. An even more difficult emotional task may be to deal with negative feelings that we "can't" feel. It may be highly destructive when careproviders can't identify and manage their negative feelings.

Careproviders may not be able to experience these negative feelings consciously for many reasons. Chief among these may be that we think we shouldn't have them. Whatever the cause, we should try to infer the presence of these feelings from our own behavior. For instance, we should suspect we have negative feelings about a patient if we find that, in interacting with him or her, we atypically distance ourselves. Distancing may be more harmful than anger.³⁰ We may have negative feelings that come not from within ourselves, but from our professional culture. We may view patients like Lorraine, for example, with therapeutic nihilism. Many members of society and many careproviders are likely to believe that patients like Lorraine act only — or primarily — willfully, and then believe that the patients "deserve whatever they get."³¹

A further difficulty is one I have already mentioned: we may encounter problems with our colleagues when we try to help patients by taking exceptional measures, such as those described above. There is an entrenched bias against helping difficult patients: the profession's cultural view that such patients *can't be helped*. It is unclear why some of us hold such pernicious views when, in so many other instances, we are able to transcend society's views. The proclivity of some patients to "act out" against their careproviders is well known.³² This is generally understood to be an attempt by patients to have some sense of power. The

particularly pernicious characteristic attributed to patients like Lorraine is that when they "act out" against staff, they do so willfully. What is increasingly clear over recent decades, but still has not yet been widely accepted, is that persons can lack the capacities that logic would suggest they have. The brain studies cited above exemplify this data.

This situation can be compounded when we erroneously think that some responses, such as setting very strict limits, will make patients better, when in fact they make patients worse.³³ What patients need most is now clear: it is not a show of power, which will only make them feel more deficient and alone; what they need is greater understanding and flexibility, which can enable them to feel and remain more in control. As Zanarini and Silk state, "After all, most of us learn more effectively sitting in a comfortable chair than trapped in a walk-in refrigerator."³⁴

We may imagine that we can easily discard views such as therapeutic nihilism. But the beliefs that we acquire from our culture, whether from society or from the profession of medicine, may be much stronger than most of us imagine. We may have negative feelings that are outside of our awareness that can harm patients; we may have cultural beliefs, like therapeutic nihilism, that are outside our awareness that can harm patients. The best chance we have to recognize these hidden cultural biases may be to not only look at our own behavior for clues, but to listen carefully to what others say about such patients. If others say that they believe that trying to treat such patients is futile, we are all at risk of believing this to some extent, as well.

CONCLUSION

The key aspect in reaching patients such as Lorraine is to become their ally. This is less likely to occur when we act as negotiators who are trying to facilitate compromise solutions. The potential gains of the approaches that have been suggested here are profound, and their risks are slight.

The ways in which we should respond can be expressed by two stories. The first is well known; it involves Helen Keller and Ann Sullivan. Although Keller initially threw violent tantrums, Sullivan remained wholly loving toward her. This was also the genius of Aichhorn, as mentioned above, and both succeeded.³⁵ Once Keller "softened" to Sullivan's assistance, Sullivan found a way to give Keller what she needed: she helped her to learn to talk.³⁶

When patients' situations are more dire, it won't suffice for us to take a "slower route" of showing total commitment and unconditional love. Immediate engagement is necessary. In this regard I think of a story I heard from a man who is probably the most skilled person in working with criminals I ever met, a psychologist named Joel Dvoskin. He was the one who taught the prisoner how to control his anger so he could gain early parole.

This is a tragic case with a tragic outcome. A man with emotional problems barricaded himself within his mobile home when police came to talk with him. His neighbors had complained to the police that he was playing music too loudly. He killed the two policemen at his door with a shotgun. He was sentenced to death, but died before he was executed.³⁷ The man had seen his psychiatrist the day before the shootings, and had had a "good session," which suggests that, at that time at least, he had been able to meaningfully relate to another person. I asked Dvoskin what he would have done if he had been at the man's mobile home before the shooting started. I said that I would have thought about calling the man's psychiatrist, who might, as an ally, have "gotten through" to him. Dvoskin responded with what I can only describe as twinkle in his eye: "I might have thrown different colors of Jello at him, and kept throwing until one color happened to stick."

NOTES

1. It is estimated that at least 2 percent of persons between the ages of 19 and 55 in the U.S. have a borderline personality disorder. M. Swartz et al., "Estimating the Prevalence of Borderline Personality Disorder in the Community," *Journal of Personality Disorders* 4 (1990): 257-73.

2. M.C. Zanarini and K.R. Silk, "The Difficult-to-Treat Patient with Borderline Personality Disorder," in *The Difficult-to-Treat Psychiatric Patient*, ed. M.J. Dewan and R.W. Pies (Washington, D.C.: American Psychiatric Association, 2001), 179-208, p. 181.
3. M.A. Leibovich, "Difficulties in the Treatment of Patients with Borderline Personality," *The Psychotherapeutic Process* 29, no. 1-4 (1978): 250-3, p. 252.
4. R.J.R. Blair, "The Roles of Orbital Frontal Cortex in the Modulation of Antisocial Behavior," *Brain and Cognition* 55 (2004): 198-208.
5. R.J.R. Blair et al., "Reduced Sensitivity to Others' Fearful Expressions in Psychopathic Individuals," *Personality and Individual Differences* 37 (2004): 1111-22.
6. J.T. Maltzberger, "Treating the Suicidal Patient: Basic Principles," *Annals of the New York Academy of Science* 932 (April 2001): 158-65, 59.
7. D.T. Saposnek, "Aikido: a Model for Brief Strategic Therapy," *Family Process* 19, no. 3 (September 1980): 227-38, p. 233.
8. "If [the careprovider] functions in one or the other role, how can he then shift into the role of helper or ally?" M.H. Hollender and S.P. Hersh, "Impossible Consultation," *Archives of General Psychiatry* 23, no. 4 (October 1970): 343-5, p. 345.
9. J. Modestin, "Counter-Transference Reactions Contributing to Completed Suicide," *British Journal of Medical Psychology* 60, part 4 (December 1987): 379-85, p. 382.
10. A. Altman and M.A. Selzer, "Delusions in Transference: Psychotherapy with the Paranoid Patient," *Psychiatry Clinics of North America* 18, no. 2 (June 1995): 407-25, p. 410.
11. S. Shapiro, "The Provocative Masochistic Patient: An Intersubjective Approach to Treatment," *Bulletin of the Menninger Clinic* 53, no. 4 (July 1989): 319-30, p. 324.
12. Zanarini and Silk, see note 2 above, p. 192.
13. For an overview of Aichhorn's work and its influence today, see J.E. Schowalter, "Aichhorn Revisited," *Psychoanalytic Study of the Child* 55 (2000): 49-60.
14. See, for example, N. Muramatsu and T. Cornwell, "Needs for Physician Housecalls — Views from Health and Social Service Providers," *Home Health Care Service Quarterly* 22, no. 2 (2003): 17-29, and "Doctors' Group Cuts Readmissions by Examining Patients in Homes," *Clinical Resources Management* 1, no. 7 (July 2000): 105-7.
15. J.S. Gans, "Indirect Communication as a Therapeutic Technique: a Novel Use of Countertransference," *American Journal of Psychotherapy* 48, no. 1 (Winter 1994): 120-40, pp. 121-122, 124-125, 131, 134.
16. *Ibid.*, pp. 126-128.
17. *Ibid.*, p. 136.
18. K.M. Dalton et al., "Gaze Fixation and the Neural Circuitry of Face Processing in Autism," *Nature Neuroscience* (6 March 2005), <http://www.nature.com/nature/natureneuroscience>.
19. H. Hendin et al., "Recognizing and Responding to a Suicide Crisis," *Suicide and Life-Threatening Behavior* 31, no. 2 (Summer 2001): 115-28, p. 125.
20. Such patients may have less reason to oppose others. The "part of their mind" whose "job it is" to be oppositional and above all "maintain control" may now "relax" more. It may allow "another part" that "wants to live" to "re-take the controls."
21. J.R. Maltzberger et al., "A Man Giving Up On Himself — Suicide & Life-Threatening Behavior," *American Association of Suicidology* 33, no. 3 (Fall 2003): 331-7, p. 334.
22. W.E. Milch, "Suicidal Patients' Psychological Attacks on the Therapist," *Bulletin of the Menninger Clinic* 54, no. 3 (Summer 1990): 384-90, p. 389.
23. R.A. Payne, *Relaxation Techniques*, 3rd ed. (New York: Elsevier, 2003). Other approaches are presented in A.W. Kneier, "Coping with Melanoma — Ten Strategies That Promote Psychological Adjustment," *Surgical Clinics of North America* 83, no. 2 (April 2003): 417-30; L.N. Gruber, "Simple Techniques to Relieve Anxiety," *Journal of Family Practice* 5, no. 4 (October 1977): 641-4.
24. ee R. Lazar, "Presentness: An Intersubjective Dimension of the Therapeutic Act," *American Journal of Psychotherapy* 54, no. 3 (Summer 2000): 340-54.
25. R.G. Poggi and R. Ganzain, "Countertransference Hate," *Bulletin of the Menninger Clinic* 47, no. 1

(January 1983): 15-35, p. 33.

26. T.G. Gutheil and D. Schetky, "A Date with Death: Management of Time-Based and Contingent Suicidal Intent," *American Journal of Psychiatry* 155 (1998): 1502-7, p. 1506.

27. Payne, see note 23 above, p. 423.

28. *Ibid.*, p. 18.

29. S. Shapiro, "The Provocative Masochistic Patient: An Intersubjective Approach to Treatment," *Bulletin of the Menninger Clinic* 53, no. 4 (July 1989): 319-30, p. 322.

30. Payne, see note 23 above, p. 427.

31. F. Yeomans, "When a Therapist Overindulges a Demanding Borderline Patient," *Hospital and Community Psychiatry* 44, no. 4 (April 1993): 334-6.

32. E. Goffman, *Asylums* (New York: Anchor Books, 1961), 304-5.

33. How those with power mislead themselves in this way is developed by Antonio Gramsci: a key dimension of inequality for Gramsci is the inability of subaltern people to produce coherent accounts of the world they live in that have the potential to challenge the hegemonic account. K. Crehan, *Gramsci, Culture and Anthropology* (Berkeley, Calif.: University of California Press, 2002), 209.

34. Zannarini and Silk, see note 2, p. 189.

35. See H. Keller (and A. Sullivan), *The Story of My Life* (Garden City, N.Y.: Doubleday, 1954): Anne Sullivan: "My heart is singing for joy this morning. A miracle has happened. . . . This wild little creature of two weeks ago has been transformed into a gentle child," p. 252.

36. Helen Keller: "Sometimes I stood between two persons who were conversing. I moved my lips and gesticulated frantically without result. This made me so angry at times that I kicked and screamed until I was exhausted." *Ibid.*, 27-8.

37. Personal conversation with Joel A. Dvoskin at a conference, "Mental Health Disability and the Law," 10 September 2004, Baltimore, Md. The person in the trailer was Francis Zito. "Zito Sentenced to Death," Associated Press, 30 May 2002, http://mdcops.org/news/zito_sentenced_to_death.htm, accessed 1 May 2005.