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At the Bedside

How Careproviders Can Acquire and Apply Greater Wisdom

Edmund G. Howe

ABSTRACT

In this issue of *JCE*, Baum-Baicker and Sisti present senior psychoanalysts' views of wisdom.¹ Although views on wisdom differ widely,² there is agreement that when ethical conflicts arise, wisdom may be critical in bringing about an optimal result. Here I will present recent empirical findings on wisdom and the ways careproviders may acquire and apply it, especially in ethical conflicts. The findings are not well-known and may seem counterintuitive; I selected them, in large part, for those reasons. A core challenge may be to decide when to give patients standard care and when to make exceptions. In this issue of *JCE*, Baum-Baicker and Sisti discuss exceptions and Bursztajn and colleagues³ consider how these exceptions may be further validated as evidence-based treatments.

WHAT WISDOM IS

Wisdom Derived from Anecdote

Baum-Baicker and Sisti present anecdotes that senior psychoanalysts shared with them, that is, insights they had gained from their patients. These insights are clinically useful because an insight gleaned from one patient may

be applied to others; whether or not we are consciously aware of it, our feelings and responses often have a great deal in common with those of others. The notion that others may feel or think as we do is a presupposition made by therapists in group therapy. In group therapy, for instance, one group member may describe how he or she was "wronged" in a situation, and, in response, other group members may feel compassion. But one member (often the therapist), may experience a seemingly contradictory emotion such as anger, because it feels as though the person may have contributed to the situation and is leaving this aspect out of the account. Other group members may also feel anger, but block the feeling because the person seems to have been "wronged," and they feel guilty for feeling angry. If the therapist shares his or her feelings of anger, it may provide other group members insight on their feelings, thus benefiting everyone. In the same way, learning about the experiences of senior analysts and their patients may help us all learn. With this in mind, let us consider some of the anecdotes.

One analyst said she thought a patient "hungry" for her touch, and so she initiated a "hands game," in which she placed her hand on top of the patient's hand, and the patient did the same. In doing this, the analyst was knowingly making an exception. She knew that she was violating, or at least bending, the so-called "no-touch rule": many, if not most, psychologi-

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cal therapies have a general taboo against touching, and this taboo can be strong. For example, during my training, a fellow psychiatric resident hugged a patient during group therapy in the center of the circle, right after she shared her emotional pain with the group. His attending psychiatrist later chastised him severely. But, in some instances, hugging may be something careproviders should do! For instance, many see Glen Gabbard as the foremost expert in psychiatry on so-called “boundary violations,” of which hugging and any touching may be examples.⁴ Gabbard says that in some situations—such as when a grieving mother tells her therapist that her son has just died, and then puts her arms around the therapist while sobbing—if a therapist does not return the hug, it “may wound the patient to the extent that she never returns to his office again.”⁵ An analogous ethical conflict that all careproviders regularly face is when to self-disclose. Self-disclosure, like touching, may harm or help. An example is when a patient is homosexual, and, rightly or wrongly, feels isolated and alone when with his or her therapist because of this. The patient’s therapist may help greatly, if she or he is gay, by disclosing this to the patient.⁶

A particularly insightful and instructive anecdote from Baum-Baicker and Sisti is that of an analyst who was treating a child who had autism. The young girl was “musical,” and the piano was “her exclusive love object.” The therapist arranged for the child to have access to a *second* piano, because the analyst imagined that the child could then play on one piano as vigorously as she needed to, without fear that, due to her aggression, she might destroy it and be without any piano. This intervention was probably costly. Notwithstanding the extent to which cost might have been a factor, the analyst first imagined and then implemented this exceptional intervention to best meet her patient’s unique needs.

Both of these anecdotes illustrate core aspects of wisdom: both analysts obviously cared; they thought up the “hands game” and the second piano, and then after thinking them up, they acted on them. These interventions, we can imagine, enhanced the analysts’ relationships with their patients most remarkably.

Evidence-Based Wisdom

In their commentary on Baum-Baicker and Sisti, Bursztajn and colleagues describe how evidence-based wisdom and anecdotal wisdom are complementary, and posit that insights gained anecdotally may be testable; such testing, depending on its outcomes, may indicate whether insights that are acquired anecdotally may apply to others. Bursztajn and colleagues suggest that careproviders should try to distinguish when anecdotal insights can be tested, and, in any case, to adjust clinical interventions accordingly. They note that patients want careproviders to use both kinds of insight: patients want careproviders to regard and appreciate them as unique individuals, while knowing and advising patients on the best available evidence-based treatments. These authors note that testing may be particularly important because insights gained anecdotally may be more likely to be wrong. That is, careproviders may make what they view as insightful inferences, but they may be idiosyncratic and wrong; they may be based on personal biases, of which careproviders are unaware. Even seasoned careproviders may develop “deeply ingrained” bad habits. One bad habit, the authors note, intending playful irony, may be ignoring available medical evidence.

Careproviders who seek to act wisely may, like the two analysts mentioned above, strive to identify and respond to each patient’s unique needs, yet remain, as Bursztajn and colleagues suggest, duly circumspect.

Still, patients’ exceptional, unique needs may lie outside what is easy to imagine. I recall a patient who said he felt sad because he wasn’t “there” for his children as they grew up, due to emotional problems he had at that time. In response, I said something I believed was a truth that could only be beneficial to him: that it was widely accepted in psychiatry that being a “good enough” parent was “good enough”—it wasn’t necessary for parents to be “perfect.” But then he became more sad, and I asked why. He said he now felt worse because he had put all of the energy he had available into his children when they were growing up—to be as perfect a parent as he could be—but now, based on what I had just said, it seemed that he should have put more of his energy into other things as well.

Further, Bursztajn and colleagues relate a concern that may arise when careproviders try to treat every patient as well as they possibly can. Such a commitment to individual patients may, in some instances, not be justifiable; for example, some careproviders “cheat” insurance companies to help patients. In these instances, the authors say, careproviders should usually work to change the system, so that insurance policies will be fairer for patients.

This consideration raises a question of when a wise careprovider should draw the line between making exceptions for individual patients and following standards of care that are sanctioned, authorized, or mandated by the greater society. This point can be expanded further. For instance, a patient called me and asked me to speak with her insurance agent. Her agent wanted to know the extent to which my patient had, during all of the time I had seen her, felt suicidal. In such instances, what should we write regarding suicidal ideation in a patient’s chart? And even, prior to this, what, regarding suicide, should we ask the patient? The patient may have only “passive” suicidal thoughts and be wholly opposed to acting on them. Should we write about these passive thoughts in the patient’s chart? If yes, should we tell the patient that, if her insurance company reads the chart, she may be seen as being at higher risk?

Here are two guidelines. First, if we inform the patient that she may be seen as at higher risk, it may be very stressful for her, and we shouldn’t leave her alone to decide what to do or say. Rather, we should allow her ample time to discuss the predicament with us. Second, in most situations when we have knowledge that a patient might see as being important, we should share it. But when, if ever, should we not share information? Sternberg is one among just a few researchers who has formally studied wisdom,⁷ and he makes a distinction that is thought-provoking: that the people who are most skilled in reflecting on ethics may be prone to drawing “right or wrong” conclusions. *Wise* people, he suggests, instead, may tend to see shades of grey.⁸ Seeing of shades of grey will be discussed below, but first, here are two cases that illustrate how hard considering whether to make an exception may be. Both cases are real.

Should We Ever Violate Cultural Beliefs?

The first case involves a teenage girl in a Middle Eastern country whose parents brought her to a small, remote clinic run by careproviders from the West. The girl had acute appendicitis and needed an emergency appendectomy to save her life. Her parents indicated they would accept lifesaving surgery on the condition that the only people in the operating room were female. The clinic had only one surgeon, who was male. The staff believed that if the family knew a male performed the surgery and saw their daughter in a partially undraped state, her parents and society would shun her. She would, for instance, not be able to marry. Ethically, what should the careproviders have done? What would they do, to be wise? Should they simply tell the family that they couldn’t do the surgery? Should they perform the surgery behind closed doors and lie?

The second case involves a much younger child whose parents brought her to a remote clinic in Africa. She was dying. Her kidneys had failed, and there was no possibility the careproviders could save or extend her life by transplant or dialysis. Her parents told the staff that if the staff said their daughter was dying, they would leave, to go home to care for their other children, because those children would survive. What should the staff do? Should they lie and not tell the parents that their daughter was indeed dying? The staff thought they might be able to “pull this off” until almost “the end” and say they hadn’t known she was dying, which would allow the parents to stay with their daughter as she died. Or should they tell the truth?

In the case of the adolescent with appendicitis, the careproviders operated, successfully lied to the parents, the patient went home, and, to the careproviders’ best knowledge, neither the patient nor her parents ever learned that the surgery was performed by a man. In the case of the younger child dying from kidney failure, the careproviders did *not* lie. When her parents learned she was dying, they left, as they said they would. Their daughter died, greatly bereaved and alone.

What might these cases suggest about wisdom? Perhaps that wisdom, howsoever defined, if it is different at all from ethics, might help in

such cases. I shall now consider how careproviders may acquire something more than ethical savvy that they could apply to such cases.

ACQUIRING WISDOM

In this section I will not consider what (wiser) careproviders might do, but how we may best proceed.⁹ As indicated, I shall rely on recent empirical studies. I have grouped these “wiser” approaches into three categories—emotional, cognitive, and motivational—although they overlap. As careproviders, we may best attend first to what we are experiencing *emotionally*. Otherwise, our emotions may be more likely to skew how we think. Second, we may use our minds to *imagine* new ways we could help, like the two analysts above, who invented the hands game and acquired a second piano. When we can imagine interventions that may help, it may not only help patients, it may also help us. It may help us feel even more motivated to help patients than before. Third, we should reflect on what our options are, and what the downside of those options may be. This third approach may be the most important, because we almost always have *some* choice between acting or not. If it becomes routine to consider all of our options and to identify the options that are more personally burdensome, it may prevent us from *not* acting based on a “hidden” reason; for example, that an particular option would be more burdensome to us.

Changing Negative Emotions

We may be most effective with patients when, consciously and unconsciously, we are less judgmental. If we are judgmental when we first meet a patient, the patient may discern this, and the good that we can do may be limited. What is the best way to proceed, to reduce these inner judgments and the associated negative emotions that come with them? Recent research suggests that, in general, the best way may not be what many of us assume.

See patients differently in ways that are positive: reframe. Recent empirical studies suggest that when we feel negative emotions toward a patient, we may do best by *not* trying to suppress the emotions. Instead, we may do better

by trying to see the emotions in a different, less negative way.¹⁰ This approach is presently referred to as “emotional reappraisal.”

Many of us usually try to suppress negative emotions as best we can, that is, when feeling angry, we might try to adopt a “poker face.”¹¹ In one recent study, some participants were asked to use an emotional appraisal approach, and were instructed to reinterpret images they saw in ways that could decrease their negative emotional response. For example, participants were shown an image of a woman crying in a church. Initially, the woman might be seen as “mourning at a funeral,” and the participants might feel sad. But they *could* see the same scene as “tears of joy at a wedding.”¹² It may be difficult to imagine how, with just this effort, we can actually be able to change what we feel, but it may actually be possible. I use this approach commonly with troubled patients. I ask them to imagine they are the last person entering an elevator, at the last minute, and that they turn and squash themselves back into the elevator without looking at anyone behind them. I ask them to imagine that they then feel a blunt, hard object poking them in the back. Most, just imagining this, feel angry and even enraged. I ask them to imagine turning, abruptly, as the elevator door opens, to look behind them, and they see what was poking them was the cane of a blind person, who thought his cane was touching the elevator door. While this example might be unlikely to actually occur, it suffices to make a “point” nonetheless: that our feelings may immediately change as a result of what we “see”—and having felt angry, we may now feel guilty.

We can use this approach to try to remove any feelings that are judgmental and negative before we meet a patient. For example, we might have prior information that a new patient has an addiction, and we may know that we tend to have a bias against patients with addictions. It is important to try to do this early in a relationship with a patient. Once a negative emotion becomes too strong, this approach may no longer work. At that point, only emotional suppression may be somewhat successful, if it is successful at all!¹³ There are other approaches that we may use to try to change negative emotions. One is to try to see things from a patient’s per-

spective. This approach is well known, but a newer finding is that, in some instances, it may be more effective to not just imagine how a patient sees things, but how a patient may *feel*.¹⁴

A final approach may work best if we develop negative feelings in response to a patient who verbally attacks us or shows anger in another way. When this occurs, we usually try not to show anger and try to suppress it. We may do better to imagine not *whether* we did something to a patient to trigger the anger, but *what* we did to trigger it—whether that is true or not. We can tell ourselves that even if we don't know how it happened, we still may have contributed to the patient's attack or anger in some way.¹⁵ It may seem an obstacle that we don't know what (if anything) we might have done, but there are many possibilities to consider. For example, we might have said something, just as we "always" do, but we may have missed a negative connotation for the patient, because the patient is a unique individual.

One example is the patient I told I was "sure" he had been a "good enough" parent, and he responded in a negative way. A second example illustrates the subtlety with which patients can feel "slighted" by their careprovider. For example, we may, without knowing it, raise an eyebrow in response to something the patient does or says. Or we might slight the patient by something we do *not* do: the patient might express sadness and we may respond in a way the patient sees as not adequately empathic. Not returning a hug, as Gabbard said, is one example.

Finally, we can never know with certainty that we have not evoked negative feelings in a patient. We can use this awareness to help quell our own negative reaction (should we find ourselves resisting this possibility), by telling ourselves we can't imagine any way we could have contributed to patients' feeling anger toward us.

See similarities between patients and ourselves. Recent studies report a relatively new finding that is ethically upsetting: we unconsciously, whether we want to or not, tend to treat others better whom we see as more like us. It may be that when we are with others who are more like us, we may be using different parts of our brain.¹⁶ If we can, with an effort, see ways in which patients are more like us, we may be

moved to feel more motivated to help them. We can try to do this intentionally before we even see a patient for the first time.

An example is C.M., the adolescent patient in the Pediatric Forum case.¹⁷ C.M. misuses illegal drugs, and we might feel bias against her for this reason. Prior to meeting her, we might try to imagine how, during stress, we might engage in behaviors that are maladaptive; we might be blocked in this empathic imagining if we think that even though we engage in a maladaptive behavior, patients who become addicted to drugs are qualitatively different from us. While this might indeed be true, there are ways we can use to "get around this." Empirical studies may help; they all report common human limitations. Here are just three. First: we all may be limited in our ability to accurately predict what we will want in our future.¹⁸ This limitation may result in our making some serious mistakes. In a classic study, Daniel Kahneman (who, subsequently, for other work, won a Nobel Prize) asked participants whether they thought they would love or hate ice cream after eating it, every day, for a week. Many in the study predicted the opposite of how they actually responded.¹⁹ A second empirical example involves what is called "priming," in which we may be affected by prior influences outside our awareness and beyond our control. For example, people may merely see the word "angry" or "nice" and then respond in one of those ways; how they respond may depend not on what happens, but on which word they just saw.²⁰ Not only may they not know the real reasons behind their actions, they may not know they aren't acting, but are reacting. A third shared human limitation is the capacity of the brain to respond quickly and automatically when it senses a possible emergency. Afterward, study subjects tended to come up with reasons for acting as they did, but the reasons may have been wrong, and the subjects may not have known this was happening.²¹ This is of special importance to ethicists: people under stress may, without knowing it, place different values on options; for example, under stress, we may value utility to a lesser extent.²²

The challenge is to use these approaches when we see a patient who seems very unlike us, for example, a serial murderer.²³ In such an

instance, we may want to use an approach similar to one described above, and try to imagine how all persons may be similar. It may be that a serial murderer is qualitatively different from us—in some or many ways—but, still, there may be a serial murderer who is not. We can't know absolutely that there is a qualitative difference, or there are many qualitative differences, or that the differences are, at least in some cases, a matter of degree. We can use this lack of absolute certainty to logically enable ourselves, when treating such a patient, to feel that the patient may be, in some way, like us. When we are "wiser" in this way, we may be able to treat even this kind of patient better.

Using Cognition

Once we reduce our negative emotions we should be better able to use our cognition. Here are two cognitive approaches that may be useful. First, we can seek new information about our patients. This may reduce a tendency to emotionally stereotype patients as "other," without realizing it, and, as a result, treat them less well. Second, we can try to see new ways to intervene for patients, as the analysts with the hands game and the second piano did. If we succeed, we may be able to see hope for patients when they can't. Seeing such a "light" of hope may move us to want to help patients more. In the same way that the approach of seeing patients as more like ourselves has emotional and cognitive components, trying to "find light," when patients can't, also has cognitive and motivational components.

Seeing Patients as Unique Individuals

Recent data suggest that the more information we have about patients as individuals, the more likely it is we can see them as being like ourselves—and so be able to care for them better. This approach is simple but may take additional time: we need to get more information, especially *idiosyncratic* information, about patients. I think of the importance that Nancy Dubler and Carole Liebman place on this process in bioethics mediation.²⁴ They accord getting this kind of information about patients as the highest priority; they call this approach "Tell me about Mama." Dubler and Liebman note,

"Important as it is to call on a physician to establish the medical facts about a patient, it is even more important to empower patients and families by asking them to begin the discussion by introducing the patient to the group." This approach establishes patients and their loved ones as experts on the patient, and so more equal with careproviders, who are experts in medicine. One benefit may be that when we do this, we have more ways to see patients as more like us, and as unique. Current research suggests this allows us to be able to treat patients better, even though this effect may take place wholly outside our awareness and control. We may be wise to maximize our capacity to help patients by asking for more information, as Dubler and Liebman do, as early on as possible.

See New "Light"

Matthieu Ricard is a French-born Buddhist monk who has logged more than 10,000 hours of meditation, and research indicates this may have enabled him to make changes in his brain, changes that might be useful to clinicians. That is, we may be able to create a special state within our brain that leaves us more able to feel "unconditional loving, kindness, and compassion." Ricard says, about meditation, that it is "every bit as demanding as weight lifting or long-distance running."²⁵ Careproviders who want to pursue meditation may want to be prepared for this level of effort, but the last approach I will describe here is not about learning meditation, it is about something else that Ricard has said that may be even more useful. Suppose, he says, that a man accidentally falls overboard from a ship in the middle of the Pacific, that he is visible to us from an airplane, and that he is about to drown. A typical reaction would be one of pity, because there doesn't seem to be anything we can do for him. If, however, Ricard says, we know there is an island nearby that the man could reach with some help, our motivation is likely to change immediately: we may feel much more motivated to do whatever we can to help him.²⁶ Surely Ricard is right. After the two analysts thought up the hands game and got a second piano, we could expect that their motivation to help their patients by doing these things only increased.

Many times I have emotionally responded when I saw a “light” that I thought could help a patient. For example, there is the patient who felt he wasn’t “there” for his children as they grew up. He was crushed when his adult son mentioned this. But I “saw a light” and told the father this comment from his son might be a good thing. Why? Because until that point, the father and son had been very distant, but now, for some reason, the son had opened up to his father, even though it might have caused both of them more pain. I said, “This could be a breakthrough! Now that he’s shared this, it may be more possible for you to build your relationship in more meaningful ways.” Merely seeing this as less hopeless, the patient felt buoyed. By imagining this possibility, I felt buoyed too.

A second example is when I see a patient with an addiction who relapses. Some care providers believe that when a patient is addicted and relapses, they should, in response, no longer see the patient. They may believe that this will be most therapeutic for the patient, and they may be right; for instance, they may believe that this is most likely to “make a dent” with the patient and may, in turn, increase the likelihood that the patient will be willing to change. But I say, in such instances, “Great! Now you may be better off than you were before. Now you may be able to recognize ahead of time—more than you did before—some of the factors that may make it more likely that you will relapse.” I say to some people who have addictions that the course of getting well takes the shape of the edge of an upward-sloping saw: their recovery may go up and down, or they may continue to relapse, but each time, they learn more about what they must do to overcome their addiction. This may help offset a likely feeling, after relapse, of shame. This response may be as helpful as any. For example, there is now evidence that people who have an addiction who “get therapy” from a computer program, rather than meeting a therapist face-to-face, may do better—perhaps because they feel less shame!²⁷ The point I am trying to emphasize here is that by attempting to see light, we may feel more motivated to help our patients, as Ricard suggests. This approach may also become a self-fulfilling prophecy: when we see light, we can share it with our pa-

tients; we can seek to be wiser by trying to see light when our patients can’t.

Increasing Our Own Motivation to Act

One way we can increase our motivation to act is seeing light when patients can’t; recent research suggests another way, and it is simple. We need to take the time to ask ourselves whether we should remain passive or act. Recent studies suggest that, in many contexts, we are all more prone to not act than to act. For example, many think it is emotionally easier to not start a life-sustaining treatment, such as a respirator, than to stop it, and there are other clinical challenges that raise the same question—whether to be active or passive. The good news is that we may overcome a proclivity to be more passive by employing our cognition: if we take the time to note our options and ask ourselves what we should do, it may enable us to choose to be active.²⁸ To be wise, we should ask ourselves regularly whether we should act or remain passive when we have a choice. We can ask ourselves this every time we see a “light” indicating a way we could intervene—as the analysts with the hands game and the second piano did. Likewise, we can go even further, and ask ourselves how much acting, as opposed to not acting, might increase our own stress.

APPLICATIONS

The Adolescent, C.M.

C.M. is a 17-year-old girl described in a case presented by the Pediatric Forum in this issue of *JCE*.²⁹ This case is as clinically and ethically difficult a challenge as one could imagine. C.M. may be rejecting her transplanted kidney, her grandmother may be dying, and she uses crystal meth. The authors of this case ask, among many other core questions, whether C.M. has adequate mental capacity to make her own decisions regarding her treatment. They note that even if C.M. isn’t legally competent, the treatment team could hardly, over time, keep her tied down to treat her! Her use of crystal meth, in and of itself, poses formidable challenges. I have been told that people who use cocaine may feel 10 times the pleasure they have when having an orgasm, and crystal meth, it is reported, may

last up to 50 times longer.³⁰ If we “do the math,” no wonder methamphetamine is said to be “much more addictive than other drugs.”³¹

The authors of the case describe edge-of-the-field interventions. Campbell notes that clinicians “must look to other tools beyond the law.” Lew notes the importance identifying C.M.’s “authentic self” and states that, if C.M. would allow it, there might be great value in shared decision making. The authors try to see things from C.M.’s view: they know that her transplant isn’t curative, but that she is “trading the disease of chronic renal failure for the disease of transplant recipient.” They recognize C.M. may have insights different from theirs, and even different from that of her grandmother, her remaining family member, regarding the burdens of her illness and its treatment. They recognize how C.M. is like them and yet unique, an approach discussed above. They recognize that “a richer narrative might allow construction of a truer picture of her person and her identity and provide a rationale for her actions and decisions,” showing their awareness of the gains of having more personal information. The one thing still missing is beyond her careproviders’ control: a bond with C.M. that would be strong enough for treatment, somehow, to succeed.

Elvin Semrad is a psychiatrist well known for his skills in forming relationships with patients; he says that this bond alone may be sufficient to protect patients from becoming psychotic.³² Havens and Ghaemi echo this thought in an article on the psychotherapy of bipolar illness. Despite the disorder’s biological factors, they write, these patients are no different from other people: “each has a self . . . [but] it may be hidden deep inside their being, under layers and layers of protection, so absent that even the person rarely sees it.”³³ They say, “We have to . . . frequently . . . bring to life an authentic self in someone who has become almost psychologically dead.”³⁴ These last three words seem to capture what C.M. may have felt. Without this bond, Havens and Ghaemi state, “all other . . . treatment efforts are impaired . . . [or] simply wrong.”³⁵ They explain how they would try to form a relationship: “we meet not as clinician and patient, but as self and self. . . And he finds us standing there . . . offering to help.”³⁶ With

medication, they say, “this alliance can . . . lead patients toward full recovery,”³⁷ and that careproviders must avoid judging patients.³⁸ These approaches described here may help us to avoid judging patients. A key is to not believe we can simultaneously help and judge patients.

Havens and Ghaemi describe an exceptional approach; they write that some patients may always need to leave a session feeling better. They offer two examples. First: “The meeting and initial work with manic persons is often complicated. When we meet with them, we collide with them. We have to confirm the collision, not deny it. Too often the collision is too abrupt, perhaps too painful, for both parties. The easiest recourse is to deny it, to go elsewhere. But the therapy moves forward because such conflict can lead to a better understanding of the other person: “ ‘Aha! That’s who you are.’ ”³⁹ Second: “If someone says, ‘I’m Jesus Christ,’ ” they might respond, “ ‘Well, I was hoping to meet him someday,’ ” or even, “ ‘Please don’t tell anyone else, because you know what they always do to the Messiah. They crucify him. I don’t want that to happen to you.’ ”⁴⁰

What might they say to C.M.? Perhaps, “I can imagine why, perhaps like you, I might want to use crystal meth. I would have it to look forward to.” This kind of response, which involves first seeing the validity in the patient’s view, is part of an approach often used with patients with addictions, called motivational interviewing.⁴¹ As when Havens and Ghaemi say, “Well, I was hoping to meet Jesus,” it may convey the emotional truth to patients that we are “in their camp,” and, to some degree, understand.

Is it possible to do this when a patient feels as hopeless as C.M.? I had this exchange with a patient with incurable cancer. She said, “I don’t know whether to get treatment or just die, because of my [adult] children.” Taking her lead, I asked, “Will they miss you?” She said, “They will, but I’m a financial burden to them.” I said, “You know, some people miss a parent so much, it’s like they lost a child. They feel an emotional void nothing can fill.” Then I grinned and said, “You know, if your children would feel this way, you might help them by increasing the financial burden. Then they might not feel your loss as much after you die.” She smiled.

The Patient with the Hair Dryer

Many of the exceptional efforts that we make as careproviders may exact a personal price. The price may be being censored by our peers for having violated the standard of care, or even worse consequences, if our innovation doesn't work and causes harm. I think of a careprovider who offered to let her patient stay with her at her home, temporarily, to help him relieve the agony he bore all of the time. She suffered greatly for offering this. We might imagine offering this to C.M.; it might have enabled her to make the transition to better health, to bear her grandmother's outcome, and to not use drugs. In the article by Baum-Baicker and Sisti, a senior analyst describes how a patient called while in the bathtub, to say she would commit suicide by throwing her hair dryer into the water. In response, the analyst said he would no longer see her. As noted above, many careproviders believe that, in such contexts, there is no more therapeutic intervention to be made. As when patients have addictions, this may be the best and only chance left to "make a dent." But there may be another possibility: a patient calling like this may create intense fear. We might end such relationships partly (or wholly) and not realize we do this to avoid *our own fear*.

Fearing our own fear, we may end relationships with patients because we are no longer able to treat them effectively. If this happens, what can we say? Perhaps: "I can't imagine how much pain you must be in to call me like this. I'm sorry, but now I feel uncontrollably afraid, and, due to my own fear, I couldn't now, despite my best efforts, successfully treat you. I'm very sorry. This is my limitation, not yours. I want to help you find another careprovider who is not too afraid to see you, if you would want me to. Can you understand and forgive me?"

In considering whether to make an exception to help a patient, we must acknowledge when, due to our own needs or feelings, we cannot. To be wise, when we assess whether we should be active to help a patient, we should ask how much pain it could cause us. If the pain is too great, we should accept this as our own limitation and tell patients honestly that this is why we are unwilling to continue to treat them.

CONCLUSION

The most important approach I wish to emphasize is the need to make exceptions for patients when, like C.M., they already feel almost dead. Havens and Ghaemi's willingness to even "Welcome Jesus" is paradigmatic of what wise careproviders might do. Jon Bowlby pioneered this emphasis on bonding in his studies of the mental health of children orphaned by war. He concluded that what children most require is a warm and continuous relationship with at least one adult caregiver—and that that need remains, from cradle to grave.⁴²

NOTES

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