Patients Who Shock Us

NORMAN A. CLEMENS, MD

When psychiatrists talk with patients, they occasionally encounter a patient who shocks them with a point of view that is radically different from their own. It is a challenge to one's professional role and therapeutic intentions, and it may seem provocative. Using two hypothetical case examples, the author explores how one responds at the moment of encounter and in subsequent therapeutic work. Starting with addressing the prevailing affect and the importance of maintaining the therapeutic relationship, efforts to identify defenses and deeper concerns may then lead to insight, relief, and greater mastery. Throughout the clinical work run elements of transference and counter-transference, including the patient's multi-layered motivations for shocking the doctor. Consultation may be valuable in this situation. On the rare occasion of fundamental incompatibility, it may be best to refer the patient to another therapist. *(Journal of Psychiatric Practice* **2010;16:340–343**)

KEY WORDS: psychotherapy, psychodynamic, transference, counter-transference, consultation, professionalism

It's the 40th reunion at a small prestigious Eastern women's college. Alumnae and significant others are enjoying a fine dinner in the company of a favorite professor from their undergraduate days. One of his former protégés in philosophy of religion was regaling the group with her marvelous findings in the realm of extraterrestrial beings and their presumed mysterious tracings in crop circles. When she moved on to her adventures in out-of-body experiences while in a state of complete sensory deprivation—how she floated up through the building roof and into worlds beyond—the elderly professor had had enough. He slammed both fists on the table and exclaimed, "No, no, NO!"

Psychiatrists don't have the luxury of such vigorous expressions of outrage with their patients. But occasionally patients do shock us. It's a moment that strains our capacity for empathy. Let's suppose that your deeply held religious beliefs hold that abortion in any form is taking a human life, tantamount to murder. Your insouciant college sophomore patient has been sleeping around and announces flippantly that she is pregnant and has arranged for an abortion *tomorrow*. What do you do?

Our professional ethics call for us to respect the patient's autonomy, to apply competently what we know from our scientific background, and not to use the patient to meet our own needs. Respect for the patient's autonomy includes respect for the patient's moral standards and for her own maturing process as she deepens her understanding of life and values. That is why you don't pound the table and yell at her—or express outrage and contempt. She is telling you about her predicament because she trusts you. She believes that you won't judge her and will help her work through her eventual judgment of herself. Perhaps she even privately hopes that you, as a wise adult, will see through her bravado and use your professional skills to help her address the misery and conflicting feelings that underlie it.

So your first move is to ask more about the circumstances, including how far along the pregnancy is, what supports she has, and how she expects to obtain the abortion. You comment that she has a very serious decision to consider and that you think it would be wise to take a little time to think it through. If this is a new patient, you need time to do a proper psychiatric evaluation to rule out major affective disorder or psychosis and to assess her personality structure. If she is an established patient, you and she need time to understand how this situation fits into the work that you have been doing together and into the transference and counter-transference between you. You are then functioning in your professional role, without intruding your personal convictions. What she does will be between her, her conscience, her educational goals, and her aspi-

NORMAN A. CLEMENS, MD, is a clinical professor of psychiatry at Case Western Reserve University and training psychoanalyst in the Cleveland Psychoanalytic Center.

DOI: 10.1097/01.pra.0000388629.21534.23

rations as a young woman who may or may not wish to bear and raise a child.

Let's suppose, on the other hand, that your political views are quite liberal and that you were thrilled to see Barack Obama elected president of the United States. Shortly thereafter, your elderly, long-standing patient enters the consulting room and declares his horror at this outrageous and terrifying development. He expects the Obama administration to take away his collection of 50 or so guns and leave him defenseless when Obama gets assassinated and the blacks rise up in revolt and take over the government. He foresees a collapse of the social order, widespread famine and looting, and racial massacres. He has plans to build, arm, and stock a bunker sufficiently to survive for months. You grip the arms of your chair and listen. There is so much that you want to say. You notice that he is watching closely as you try not to tighten your jaw. He goes on to detail the notion that he, his wife, and a group of like-minded people will buy a farm in the country and build a self-sustaining community that can survive the chaos. You contain yourself and remark that he seems very frightened and is trying to find ways to cope with what he sees as a very threatening situation.

What are we trying to do here? This is a delicate clinical challenge. The following elements come to mind, although they would not necessarily be addressed in a particular order.

Maintain the therapeutic relationship and respect for each person's individuality. This is obviously the substrate for everything you do. If these patients do not trust you to respect their personal world view and their right to make their own decisions, they will leave therapy and you will have no chance to help them. At the same time, they expect you to maintain your own personal and professional integrity and give them the benefit of your perspective. Less consciously, they attribute to you a great deal that comes from their past experience, good or bad, with parental and authority figures in their lives, which may be very different from who you are but very hard to address in the midst of a crisis.

Identify key affects. In both hypothetical cases described above, the underlying affect is central. The pregnant college girl's bravado barely conceals her anxiety, chagrin at being caught in this situation, guilt about her sex life and the abortion, shame in telling her therapist about it, fear of wrecking her education, and perhaps a sense of loss about foregoing the chance to have a baby. Above all is the anxiety, the uneasiness stirred by an inchoate mass of emotions she has not fully identified. In psychoanalytic terms, anxiety is the affect stirred by the danger of being internally overwhelmed by forces that are out of control. She hopes that you can see beyond her fragile defenses and help her feel less lonely and confused.

The survivalist is terrified by what he perceives as extreme danger. Never mind that what he dreads seems preposterous to you; your task is to glimpse it through his eyes. You know that it is fed by radical, raging, catastrophizing rhetoric that surrounds him in his corner of the media and the blogosphere, so it is shared by others and is not a personal delusion. He needs to restore his faith that the American republic and the social structure he fought to defend when he served in the armed forces will survive this challenge, changed but still holding a safe place for him. By tactfully connecting with these underlying emotions, you can get past your own aversive response and relate to the patient with familiar professional skills and style.

Assess the patient clinically. Needless to say, one has to do what it takes to reach a sound multi-axial diagnosis, including Axis II, the personality substrate of the crisis of the day. Supposing that the survivalist is well known to you from a long record of therapy dealing with severe marital problems and a somewhat paranoid personality—you are then well prepared to conclude that he is not psychotic. Despite his glib talk and his bluster, he seeks direction and is completely dominated by his wife. Both are concentrated on protecting themselves and their basic needs. He gives no indication of imagining himself as the hypothetical presidential assassin. You assure yourself that there is no risk of his being a danger to himself or others, unless attacked, though both he and his wife are expert markspersons. From your past experience with this fairly easily redirected individual, you know that he respects you and your viewpoint, despite his having figured out long ago that your viewpoints are liberally inclined. You decide that you can help him rethink some of his fears and focus on constructive solutions.

The college girl may worry you more, because of the possibility of an incipient mood disorder driving her to manic hyper-sexuality or threatening a pre-

cipitous fall into suicidal depression. You pursue the details that help you assess these possibilities and their inherent risks, and you arrange to follow the patient closely. You consider a possible need for medications but are reluctant to use any drug that might cause fetal abnormalities, should the patient change her mind about the abortion.

Look for the underlying dynamic processes, including defense mechanisms. In talking with the survivalist, you notice that this session is different from the usual litany of complaints about his hypochondriacal, bullying, ranting wife and his helpless inability to set limits on her behavior or to get away even for a visit to out-of-town family. You learn that she has a new health problem that could be life-threatening, and you wonder aloud if he is so alarmed by the new political situation and feels so personally vulnerable because he is genuinely frightened by the threat to her life and the possibility of her not being there to meet his needs, leaving him alone in the world for the first time. You are interpreting the displacement and projection that moves the threat to the outside world. You may also be sensing that his fears of violence in the larger world and his focus on self-defense might reflect his projective defense against deep well-springs of rage and aggression within himself.

As already suggested, the college girl is using bravado to push away awareness of fear, anger, shame, guilt, and perhaps ultimately sadness and loss. She may feel alone, confused, and abandoned in a moment that involves life and death. She is ambivalently turning to you to sort things out. Much will depend on what you learn about her relations with her parents and their moral standards. Is she in defiant rebellion against them? Does she feel that they have turned her out into a dangerous world she is unprepared to deal with? Is she acting out some drama that has its roots in her Oedipal-phase relationships with them? The possibilities could go in many directions once you have enlisted her partnership in understanding what is happening in her life.

Assess the transference/counter-transference situation. The college girl may be testing you to see if you will betray her through being moralistic and judgmental, rather than working with her to deal with her own motivations and self-judgment. She wants to know if you will be there for her at a very trying moment in her young life—*in loco parentis*, as it were, in a supportive sense rather than an authoritative one. Will you be attuned to her special needs as a young woman? Your gender will make a difference to her: if you also are a woman, will you be intuitively aware of her feelings about sex, pregnancy, and motherhood, as well a good role model in working through the crisis? And if you are a man, will you be fatherly, wise, kind, and protective or will you be punitive or seductive or voyeuristic about her sexuality? Your insights about her dynamics will have to be paralleled by awareness of your own dynamics.

Knowing the survivalist well, you might have detected a somewhat playful and provocative tone in some of his remarks, which included a jab about how Obama's allegedly promised socialized medicine would reduce doctors to mere slaves of the state. You might have humorously remarked that maybe he blamed his liberal doctor for the impending disaster, and so managed to express his anger and his fears at the same time he was tweaking the doc. His ambivalence towards all authority—parents, his dominating wife, the government, and his psychiatrist—comes through in his defiance against those on whom he also passively depends for protection and direction. He then tells you that he has never lived alone—went right from his parents' home to the armed forces to his long marriage—and is uncertain how he would survive without his wife if she died.

Facilitate problem-solving and realistic decision-making based on greater understanding. Insight is not enough by itself, although it will probably be very helpful in identifying and dealing with more specific affects so as to calm diffuse anxiety about the crisis. People feel more in control under stress if they know what they are dealing with, including their own feelings and inner conflicts.

Sometimes you will have to support reality-testing and try to do so without violating the patient's autonomy. This was done early in the hypothetical situation with the pregnant college girl, by focusing on the realistic details of the predicament and trying to establish a space for thinking through the immediate situation together. It is also done as you assume a professional attitude and calmly conduct a proper evaluation.

With the survivalist, you might suggest that people on all sides have a vested interest in preserving the American democracy, no matter who is president,

and in avoiding social chaos. You comment on the extreme nature of the radical blogs and newsletters he is reading and express some surprise that, with his high educational level and intelligence, he isn't also reading publications with a different or broader point of view, so he can decide for himself instead of being so dependent on people with an obvious bias. He calms down, perhaps identifying with your calmness and efforts to think things through. As time goes on, he and his wife buy a farm in the country, get involved in furnishing and upgrading it, find that the woods are a great place for their target practice, and begin to enjoy their rural surroundings. Eventually, they discover that its proximity to a major highway presents some commercial possibilities. And the sky hasn't fallen yet.

Recognize and confront irreconcilable incompatibility. Not every story has a happy ending. Regardless of one's professional training, skill, healthy personality, or ability to see the person beyond the provocative, shocking presentation, we all could probably find someone with whom we are just too uncomfortable to work effectively. After a reasonable effort to understand the patient and ourselves, and to establish rapport and a working alliance, there may inevitably come a moment when we or the patient realize that this is just not going to work. There is no shame in this, and it can happen in any specialty of medicine. We may offer to help in finding another therapist, but the patient may see such a referral as tainted. We may make ourselves available in the event of an emergency in the interim, or give the patient the name of an emergency service to call, and go our separate ways. We document this carefully and perhaps convey it to the patient in writing. It's not a failure, just a bad match.

In writing this, I recalled one of my favorite books, which I consider a classic. Brian Bird was one of my early psychoanalytic professors of psychiatry. His *Talking with Patients*[1] was written for medical students and physicians in any specialty. It describes many different emotional states that patients bring to the doctor's office and explains how the doctor can respond appropriately on the basis of psychodynamic understanding of those states. I am sure that Dr. Bird's attitudes started me on the path that led to this column.

Reference

1. Bird B. Talking with patients, 2nd edition. Philadelphia and Toronto: J.B. Lippincott; 1973.