

Maintaining Empathy in a Locked Psychiatric Unit

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Recently, a colleague and fellow psychiatrist who works in an adjacent locked psychiatric unit was the victim of an attack by a patient. He replayed the scenario to me, and 1 of the scariest things about the event was that it seemed to occur without any provocation: the male patient lunged over the nursing station, grabbed him by the collar of his white coat, and proceeded to assault him. Although the incident was broken up by staff fairly quickly, the physician was still struck several times in the face and head, which resulted in a bloody nose and a black eye. The assaulting patient was a young man in his early 30s who was suffering from paranoid schizophrenia, as evidenced by bizarre and persecutory delusions and auditory hallucinations. He was brought into the hospital by his family because they suspected he had stopped his antipsychotic medications and they were concerned about his bizarre behavior.

At first, I did not know how to react. I impulsively considered taking karate classes or stopping wearing neckties, viewing all patients as potential assailants. In the days that followed, I became much more timid when seeing patients and walking the hallways. I noticed myself perpetually searching for danger and constantly looking for clenched fists, misplaced hostility, or signs of lability. This preoccupation with potential danger began to affect how I conducted myself. Part of me wondered whether my patients sensed the change or maybe even detected my fear. It was only then that I considered the entirety of the situation—admittedly with some difficulty—and considered the incident from the patient's point of view. The attack was not the criminal action of a sociopath, but rather an outburst by a patient with mental illness who was feeling afraid and trapped in an environment he was desperate to leave.

Determining another's motives, especially in the case of a psychiatric patient, can be a difficult prospect. Whereas motives and actions can make complete sense in the mind of the patient, they often seem irrational to the observer. When trying to determine a psychiatric patient's perception or motive, sometimes I feel like a detective, trying to piece together a puzzle with the critical portion missing.

In the event of an assault, it can be easy and natural to despise a patient, because a clinician's behavior would rarely warrant an attack. Although I have never been assaulted by a patient, I have found myself with deep feelings of malice toward several of my patients. Malicious thoughts may not seem altruistic, but they can be invaluable in treating a patient. When I realize and accept these feelings, I am able to view my thoughts as part of the patient's treatment. If I, as his treating psychiatrist, feel this way, how must every other individual in the patient's life feel? Once these emotions arise, I find it essential to remind myself that the patient's conduct and behavior are symptoms of a disease and to refocus my thoughts on being empathic toward the patient. If you are able to envision a world in which your actions cause most people to dislike you, you can begin to imagine the lives of certain patients. I find that this helps me empathize with the patient and, on another level, empathize with people in the patient's life.

Currently, I am a psychiatrist on a psychiatric unit for people with chronic mental illness. At any given time, I may treat between 20 and 25 individuals with a primary psychotic illness. Their lengths of stay vary and can be indefinite, from 2 months to 9 years. The severity of mental disorders of this patient population leaves me frustrated and doubting my skills as a clinician. Finding empathy in these deep moments of frustration can be a steep challenge, but empathy cannot be avoided; otherwise, I risk burnout and ubiquitous unhappiness. When I miss an opportunity to examine a patient's inner world, I also miss an opportunity to unburden my frustration and doubt. In general, taking a step back and attempting to understand a patient can make confusing and frustrating symptoms seem clearer.

If psychiatrists look only at the symptoms of patients, they may be able to treat the patients, but they will not have truly made an effort to understand the patients. A patient needs to be viewed as more than just a set of symptoms or a case file; rather, a psychiatrist should treat a patient as a complete person—taking into account biological, psychological, and social precipitants of the patient—and in so doing truly exemplify the body-mind-spirit tenet of

osteopathic medicine.¹ It would be much simpler to say, as many of my nonpsychiatrist friends often do, that a person is “crazy,” rather than to attempt to view the world as the patient does. It is in light of this reductionist view that the concept of empathy needs to be reinforced in medical education.

I recall reading a controversial article by Rosenhan² during my internship that described the experience of pseudopatients admitted to various psychiatric hospitals. What I found most disturbing about the article was the physicians’ depersonalization of the pseudopatients, making some feel like they were invisible. The aloofness that was once considered normal “bedside manner” has evolved into an expectation of empathy,³ a development that is being reinforced by medical education. Studies^{4,5} have identified how student empathy declines during medical school. All the more troubling is that the decline typically occurs during the first year of direct patient care (the third year of medical school). Patients can be challenging to relate to. Not all of them will be sweet and admirable. In fact, some patients can evoke physicians’ feelings of antipathy and aversion. These patients have been famously termed *hateful patients*.^{5,6} Hateful patients make being empathic a struggle and can test the limits of any physician. Typically, hateful patients are those with personality disorders, psychotic disorders, or both.⁶ Considering that nearly every patient I see has a psychotic disorder, I can say that not all patients with psychotic disorders evoke malice, but, unfortunately, some truly do. Rather than ignore these feelings, physicians should embrace them, as physicians may gain important insight into the patient’s inner world and psychological state. As I of my mentors frequently says, “All can be grist for the mill.”

I am bombarded daily with claims by patients that I stole their money, that staff is poisoning their food, or that I am really an imposter. At times, these persistent delusions can invoke a type of “helplessness in the helper,” but the delusions need to be viewed in the context of mental illness.⁸ Maintaining a grip on compassion and empathy is a prerequisite for treating patients with mental illness, and if cynicism and hostility are allowed to fester and manifest, treating these patients becomes all the more challenging. Not only will a physician’s conscious drive toward empathy result in a better therapeutic alliance and patient outcomes, but it will also decrease physician burnout and helplessness. I search for any sign of patient symptom improve-

ment and cling to it, because that can be the “carrot” that allows me to persevere.

It took time, but my inner turmoil about the attack on my colleague subsided. The patient was clearly ill and not thinking logically, and had I considered the entirety of the patient I would have saved myself considerable angst and doubt. Furthermore, if I was the one attacked, I hope I would be able to recognize the assault as a symptom of illness rather than as an intentionally hostile act. Perhaps I am no longer as naïve to the signs of hostility as I once was, but I am no longer constantly searching for signs of danger. I believe I view patients holistically and treat patients with a level of empathy and respect that I would hope to receive if I were a patient. I continue to strive to embody the osteopathic maxim that physicians should have “a willingness to listen to patients and respect their views by exhibiting elements of altruism and empathy.”⁹ This maxim not only makes for a better physician, but also helps foster a better therapeutic alliance with patients. Realistically, it is impractical to have each medical student spend 24 hours on a psychiatric unit, as students in Rosenhan’s study² did, but I wonder if the medical profession would not be better off if they did.

In the end, I decided against taking karate classes. But in the interest of disclosure, I now wear just a shirt and a sport coat—no necktie required.

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