

In 2004, I was asked to be the lunchtime key note speaker at the Orange County MHA's annual Meeting of the Minds conference. I had presented my four stages of recovery model in a workshop the year before and they wanted me to return. However, they had a very unusual task for me. The theme of the conference was fighting stigma and they were going to set up a "Brown eyes – Blue eyes" experience for the conference participants and they wanted me to facilitate a group processing of the experience when all 400 of them were gathered for lunch. Needless to say that struck me as beyond my group processing skills. Besides which, I'd never heard of "Brown eyes – Blue eyes" before.

They explained to me that "Brown eyes – Blue eyes" is an experience where people with brown eyes are systematically favored over people with blue eyes creating an "us vs. them" "superior people – inferior people" situation. In a number of settings ranging from schools to board rooms when this is done a striking amount of prejudice, bigotry, cruelty, and self-deprecation emerges within a day. In one situation in a YMCA board retreat someone was so traumatized they tried to sue the facilitators. To avoid any severe damage, since there were going to be a number of consumers at the conference who might be vulnerable, they limited some of the systematic favoritism that is usually done. They decided not to segregate parking or bathrooms, not to ban blue eyed people from some sessions or make them sit in the back, and not to make them eat separate lunches in separate rooms.

I agreed to take on this task and took a high risk approach. I began by describing the intent of the "Blue eyes – Brown eyes" experience to the audience and asked them to talk briefly at their lunch tables about their reactions. Then I told them about the decisions the conference organizing committee had made to restrict the experience to avoid hurting consumers and asked them by a show of hands to indicate which of the restrictions on systematic favoritism they thought were advisable and which were unnecessary. Then I asked them how many of those same systematic favoritism items were in place every day at their program separating staff from clients. Most of the very same things they thought were too mean and risky to do for half a day they were doing every day to their clients without even thinking about it.

I went on to point out that earlier in the day they had come up with dozens of examples of stigma created by our communities, but none that are created by us. It's time for us to look more piercingly at ourselves. They also had come up with numerous suggestions to educate people to reduce stigma. I told them that I didn't think education was the antidote to stigma. I thought emotional connectedness was. It's time for us to look more piercingly at how and why we stay emotionally disconnected from the people we work with and how that feeds our own stigma. This paper is the speech I launched into.

Up Close and Personal: A Plea for Emotional Closeness with Patients

(2004)

UP CLOSE AND PERSONAL:

A Plea for Emotional Closeness with Patients

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I went to medical school intending to become a psychiatrist. I was excited when finally, in my third year, I got to my first clinical rotation in psychiatry at Malcolm Bliss State Hospital in St. Louis. I was looking forward to spending time with “real” mentally ill patients. I rapidly figured out that if I just sat in the day room lots of patients would come up to talk with me. Soon, however, one of the nurses came out to chastise me, “Don’t sit there talking to the patients like that. You’re only here for six weeks. They’ll just get attached to you and then they’ll be hurt when you leave.”

There was more to it than that. No one was talking to the patients. The nurses all hid behind a glass wall in the nursing station, studying charts and talking to each other, only coming out to do their “patient checks”. The psychiatrists, mostly foreigners, were on another floor entirely, in the library studying for their exams. And the psychologist only appeared once when we admitted a fragile, traumatized young woman he thought might be appropriate for psychotherapy. The patients, hungering for attention, or at least acknowledgement, tended to clamor at the locked windows and doors. Eventually most gave up and withdrew quietly to their rooms waiting for smoking breaks. I had seen this avoidance of emotional contact, and even basic conversation, on many other medical and surgical services, but this was psychiatry. Weren’t we supposed to help people by talking with them?

Even at the Menninger’s Institute, a famous psychoanalytic hospital where I spent time in my fourth year of medical school, conversation had to be carefully limited. I spent some time talking to a young man about his beliefs that satellites were putting thoughts into and out of his head. My supervising psychiatrist also chastised me, “Stop talking to him about the satellites. Don’t you know that you’re feeding into his delusions?” I didn’t know enough then to wonder how we were going to build a trusting relationship with him without talking about the things in his life that were the most powerful, disturbing, compelling experiences that he’d ever had. Ironically, the psychiatrists’ interpretation of his patient’s delusions was that he was feeling unable to communicate and had the unconscious fantasy that his thoughts could be shared directly without needing speech. Maybe some normal conversation would’ve helped him.

As medical school went on, I found two islands where connecting emotionally to patients wasn’t discouraged: A substance abuse treatment program and a hospice. When I told the recovering addicts, who were running the rehab unit, my story about wanting to talk to the patients in the day room, they were thrilled, “Finally a med student who’ll be able to help people.” The family practice doctors who ran the hospice actually encouraged me to share their patient’s worlds, to write letters for them, watch

T.V. with them, wash their feet, to reminisce. They wanted me to learn to care for patients instead of cure them. I also learned a valuable lesson: The most difficult and frustrating patients that overwhelmed standard medical and psychiatric care could be helped by connecting emotionally with them.

I hated getting up early checking stitches, fluid balances and labs on surgery rotations, so I made a deal with the surgery residents. I would talk to any patient who had a problem they didn't want to deal with (consents for surgery, pain management, grief and anger mostly) and I wouldn't have to get up early to do the checks. The ward ran wonderfully. I made almost all the problems go away just by talking to the patients.

When I ask psychiatric patients who have done well, what I did that was helpful to them they rarely answer: "It was that brilliant combination of Depakote, Risperidone, and Zoloft you gave me." They almost always recount some moment of human connectedness: "It was when you hugged me and I could tell you knew how much it pained me to have my child taken away." "It was when you believed in me, when I couldn't believe in myself." "It was when you lent me \$5.00 even though you're not supposed to." "It was when you drove me home from the hospital in your car even though I was smelly." "It was when I knew you really cared and wouldn't give up on me." Almost all of those healing moments are "against the rules" of my profession: Don't share yourself, don't break boundaries, and don't get emotionally involved.

I was taught two major reasons for these rules: First, getting emotionally involved clouds our rational judgment. Second, getting emotionally involved makes it harder to act decisively. Although these both sound reasonable, they both produce strikingly disturbing outcomes.

Rational judgment is one of the foundations upon which the medical profession is based. We break down problems patients present us with, collect and analyze data, scientifically study syndromes and interventions, and base our diagnosis and treatment on scientific research. The problem with this methodology is that it only works for relatively simple problems that can be broken down and studied systematically. If things get too complicated we're stuck unless we try a more holistic approach. Unless we're theoretical physicists or symbolic mathematicians or musical composers we're likely to have to use our emotions and intuition as our holistic tool.

For example, when today's complex computers malfunction and we call in an expert to help, he does not progress through a rational analysis of the problem. He sits down and tries to "get a feel" for what's wrong. He literally creates a holistic relationship with the computer to fix it. That's why he can't tell us how to fix it next time. Why does he do this? Because computers are too complex to diagnosis and treat rationally. So are humans and doctors used to know that. That was the basis for the "art of medicine." Not coincidentally those doctors used to relate to their patients as whole people.

I once read a book by the director of the medical diagnostic clinic at Stanford. He estimated that for about 40% of patients he could find some physical condition that seemed to be connected to their complaint (like finding a streptococcal infection in a patient with a sore throat). For another 20% he found a physical condition that might be connected to their complaint (like finding high blood pressure in a patient with a headache). But for the remaining 40% he couldn't find any physical condition connected to their complaint. His plea was that doctors should stop doing more and more tests vainly looking for a treatable condition and instead look at the person's entire life. Or, in my words, we should give up rationally breaking down the problem and connect emotionally to get a holistic understanding.

It has been claimed that the most common diagnosis in Medical Emergency Rooms is “battered woman” but that it’s hardly ever made. I’d argue that’s because “battered women” is a holistic diagnosis that is very hard to identify entirely rationally without “getting a feeling” that something bigger is wrong.

In psychiatry, the drive to rationally diagnose and to become scientific professionals, has led to the creation of the amazingly fragmented, overly simplified, rarely explanatory Diagnostic and Statistical Manual. I have a psychiatrist friend who says, “You’d better diagnose someone rapidly before you really get to know them and realize they don’t fit into any pigeon hole”. DSM’s approach to complexity is not causal understanding or holistic connection, but rather to stack numerous oversimplified diagnoses on top of each other on multiple axis. The end result of making sure emotional involvement does not cloud our rational judgment is a fragmented, overly simplistic, formulaic diagnostic system devoid of almost all true wisdom; labels without meaning.

Now to the second rationale: I’ll admit that it is difficult to act decisively while we’re emotionally involved. I struggled as a medical student to start IV’s in people’s arms because I was concerned about hurting them. Sticking long needles into the backs of crying children was almost impossible for me. Staying emotionally detached makes it possible to act without considering the emotional impact on our patients. But how much “inconsiderate intervention” do we really want from our doctors? Maybe a little in an emergency, but usually none for chronic illnesses. As a psychiatrist I was taught to “inconsiderately intervene” by hospitalizing people against their will, tying them down, and forcing them to take medications. Is that what we really want from our psychiatrists?

In summation, I would claim that our salvation from psychiatry based on fragmented “rational diagnosis” and “inconsiderate interventions” depends on us connecting emotionally with each other.

Many people with serious mental illnesses feel that they are more disabled by stigmas than by symptoms. When we give this view any credibility at all, we start by blaming the media and social stigma, rather than looking at our own prejudices. We invariably prescribe education as the treatment for stigma. I don’t agree. If education was the solution, then doctors should be very low in stigmatizing behavior and attitudes. All of us know this just isn’t true. It seems to me that stigma is most effectively combated with emotional connections. The old cliché goes “I hate black people ...well except that one I know ... and she’s an exception too, she’s nice...and not him either”... and so on until the prejudice dissolves away.

Our field routinely, and generally unintentionally, does enormous amounts of segregating, prejudicial, stigmatizing things to our patients. We make them use separate bathrooms and eat separately. We keep watch over them in our waiting room with armed guards to keep us safe rather than protecting everyone together. We don’t hire them or even socialize with them. We urge them not to have sex, get married, or have children. We set up segregated housing for them. We separate them from other medical patients and other social service recipients. I could go on and on.

In summation, I would claim that our salvation from disabling stigma depends on us connecting emotionally with each other.

So what’s really going on here? If emotional connectedness is what our patients want, what’s most likely to help difficult, frustrating patients; if it could reduce fragmented diagnoses and inconsiderate interventions, and dissolve disabling stigma, why aren’t we doing it? I don’t think it’s because of the usual

suspects - professionalism, psychoanalytic counter transference concerns, ethical concerns about how we'll misbehave if we lower boundaries, or even fears of liability and getting sued. I think there are three powerful emotional reasons for distancing ourselves: (1) We don't want to feel our patients' disturbing feelings because we are afraid we'll be "burnt out," (2) We don't want to lower our defenses because we don't trust our patients, and (3) We're physically frightened of our patients because we've experienced serious violence at work.

Many of our patients experience truly terrible emotions. That's usually why they come to see us. One man once told me, "Being paranoid is like being in a Nazi concentration camp knowing you could be tortured or killed at any moment for no reason, except that no one ever comes to liberate the camps and no one believes you that they exist." Another woman told me, "Having your child taken away is like having your heart ripped out of your chest, leaving an enormous black hole that no matter how much you cry just goes on aching."

Part of us knows or vaguely remembers that we have to share these feelings with them if they're really going to heal. We can't just toss them a diagnosis and a pill. But can we really handle it? Won't we burn out? "Your job must be very hard on you," our friends tell us. "I don't know how you do it." If we were being honest, we would admit that mostly we don't "do it". We block out feelings. We keep patients at a distance. If we were being honest, we'd have to explain why we're in mental health at all, if we're not doing it with feeling. If we were being honest, we'd wonder if we were actually helping anyone this way.

I agree with Patch Adams on burnout. I think burnout is not from feeling too much, but from trying not to feel. We build burnout when we block out our heart-felt responses and deaden ourselves a little to avoid the pain. Feeling too much doesn't burn us out, it frightens us, and makes us feel small and vulnerable. We instinctively respond to fear by lashing out in anger or by hiding away by ourselves. It's those reactions that harm patients far more commonly than true neurotic counter transference.

If we work by ourselves in small rooms one-on-one, walled in by confidentiality rules, with nowhere for the feelings to go, we're at our most vulnerable and won't be able to handle much. If we're part of a team, if many people are emotionally involved, if our program is full of life and support for us, we can experience more feelings with less fear. And our ethics will be less likely to get lost along the way. A supportive community is the best setting for safely lowering boundaries and healing emotionally. We can do more together than we can do alone. Although it feels unnatural, we know that in truly emotionally frightening situations (9/11 for example) it's best to reach out to each other, not to barricade ourselves alone.

We do have to be aware of when we're feeling our own feelings and when we've become characters in our patients' emotional dramas. We can only begin to take responsibility for our feelings and to give back to people their feelings to take responsibility for, if we actually feel. If we don't have a lot of psychodynamic background or training it's often helpful to ask everyone else: "Is everyone feeling angry at John or is it just me?" "Is Susan making you guys feel like wanting to be a strong, protective man too?" If psychodynamically trained "therapists" are members of an open team instead of working in isolated offices, there's a good chance, as feelings are openly shared, of everyone learning how to be more emotionally healing.

Almost every clinician has been emotionally hurt by their patients. Usually it's small hurts like being lied to, or unfairly lashed out at in anger, or manipulated, or showered with ingratitude. Sometimes it's big

hurts like being falsely accused of sexually molesting a patient, or being sued unfairly, or being reported to our supervisor and getting fired, or being blamed in their suicide note. The small hurts make us more defensive and can gradually distance us from our patients. The big hurts can be truly traumatizing. We may disconnect entirely or put up massive defenses. Sometimes we're not even aware of it.

Once I was talking about this issue with a middle aged social worker, who said she couldn't relate to patients like friends because she couldn't trust them. I helped her remember why: When she was an intern she was diagnosed with cervical cancer and had to leave work for a month for treatment. When she returned to work, her patients weren't at all concerned for how she was or what illness had forced her to leave. They were angry with her, "How could you leave me when I am going through so much?" She'd forgotten how hurt she felt by them, but from then on she's "known" not to expect any caring from her patients.

So, what's wrong with that? Our patients aren't "there to make" us feel cared about. The problem is that we'd like our patients to grow enough to have emotional connections with friends instead of with therapists and they'll have a great deal of trouble keeping friends if they don't learn to care about the people who care about them. That social worker was inadvertently teaching her patients not to care about her, which may well have the impact of keeping them friendless and relying on therapists forever. The more real we are with our patients the more likely we're teaching them how to be able to be friends with real people and not need us forever. Certainly there are goals to therapy beyond paid friendship, but far too often not having friends keeps patients needing us far too long.

Sometimes patients physically assault staff. This can frequently leave us seriously traumatized. One day one of my very aggressive female patients was hospitalized out of control. When the very sweet nurse wouldn't take her out on a cigarette break fast enough, she shoved her down and kicked her in the head opening a large bleeding gash that required eight stitches. The nurse was literally and psychologically stunned. She took off a couple months but never really recovered. She went from being a warm, empathetic soothing nurse to cowering and trembling, too frightened to reach out any longer. A wonderful healer was lost to us. No matter what apologies or amends I got the sincerely regretful patient to reach out with, the nurse couldn't respond.

Even when it's someone else who has been hurt we can all be affected. I had a close friend, a young woman social worker who worked as the clinic's sole homeless outreach worker. For several months she had been trying to work with a man who had severe schizophrenia, was very delusional, refused all medications or assistance, and lived in garages that were left open. The neighbors were frightened and disturbed. When the police arrested him the judge ordered him to receive counseling, not medications or housing. My friend had been bringing him lunches on the street and went to court to support him. Several weeks later he came into her office, where she was alone. He thought she was the Devil so he pulled out a knife and stabbed her 27 times. The screams stopped when she died before anyone arrived to help her.

This was extremely tragic, not just for me, but for many others. There was a candlelight vigil, a crowded funeral, and the clinic held meetings to help process our feelings. Several staff took leaves and many even quit. I met with a group of troubled coworker friends for dinner over and over. Knowing statistics that mentally ill people are no more dangerous than anyone else was of no assistance.

Ultimately, I had to make a decision. Either I was going to feel betrayed by my patients and distance myself from them, or I was going to feel betrayed by the mental health system and distance myself from it. Either “Why put myself out to help these people when they killed my friend? Forget it, they’re not worth it,” or “Why did we send out a little woman all by herself to do “counseling” with a dangerous psychotic man without any real treatment available? That’s not a system. It’s a human sacrifice.” Ultimately I chose to stay very close to my patients and to leave county mental health and work for the Mental Health Association devoting myself to radically changing the system that betrayed us.

I’m proud to be the first full-time psychiatrist hired by the Mental Health Association of Los Angeles. One of the things I like about MHA is the logo of the MHA bell on our business cards and stationary. The story of the MHA bell goes something like this: In World War II there was a set of conscientious objectors, mostly Quakers, who were assigned to work in mental asylums instead of fight in the war. The combination of decrepit, inhumane institutions and these highly principled workers proved a volatile one. They engaged in substantial advocacy efforts. The most symbolically powerful of these efforts was to create the MHA bell. They collected up the iron chains and cuffs that had been used to literally chain patients to their beds and the walls. They had them brought by train from all over the country and melted down into an enormous bell. On it is inscribed a message something like “from the chains of our enslavement let freedom ring from our eventual triumph over mental illness”. When I’ve retold this story I’ve always visualized the moment of triumphantly striking the bell.

However, for that moment to have been possible there must have been many other moments in the months that preceded it, where some staff literally unchained some patient. That staff must’ve hesitated in fear, wondering if he was going to be attacked. He must’ve reached out as though untying a wild animal, hoping, and trusting a little, that he wouldn’t be hurt. And on the other side, there must’ve been a patient, filled with anger, sorely tempted to lash out against his captor who had led him by a leash to the toilet the day before, who decided not to attack. The patient had to hope, and trust a little, that the staff was really going to help him this time, when he accepted the staff out stretched hand.

That moment, on both sides, is the moment in which healing and recovery are possible. That is the moment when fear and mistrust is put aside enough to reach out honestly and caringly to each other. That is the moment that makes emotional connectedness possible. That is the moment that makes triumphant bell ringing possible.

If we are to be honest, each of us, staff and patient alike, face that moment every day. We can’t keep responding, “The rules force us to keep them chained,” or “It’s too risky,” or “I’ve been hurt too many times before.” We must courageously reach out to each other every day.

You may be interested to know how the audience reacted to this speech. As I read it today it strikes me as so raw and so confrontative I can hardly believe I gave that speech. At the time I had no idea what would happen. As I hurried down from the podium that day I was shocked by the most powerful standing ovation I have ever received. I had emotionally connected with almost everyone in the room. Not since I gave my first “A Road to Recovery” speech had I stumbled on something so powerful.

A tape was made of that speech by a consumer on the organizing committee who absolutely adored me and advocated heavily for me to be featured in their conference. She had put a cheap battery operated

tape recorder on the podium to try to capture my words. I received the tape about six months later along with a letter from a friend of hers. The friend apologized for the long delay in sending the tape to me. She went on to explain that she had found the tape in the woman's apartment when she was going through her belongings after the woman had killed herself.

Sometimes tragic things happen to people we care about in this business and it hurts. I haven't played that tape since then.