recently, a psychiatric resident, distraught and worried by the erratic and resistant behavior of a patient, came to me for advice. The patient was a 20-year-old college student who had come to the psychiatric outpatient clinic because, as he had said, "some tests" in a psychology class indicated that he had attention-deficit/hyperactivity disorder (ADHD) and he wanted treatment for this disorder. When he talked with the student, the psychiatric resident could find no evidence to support the diagnosis of an attention deficit disorder—however, he did discover that the student had many other very severe problems. The young man had been depressed for several months with severe insomnia, anhedonia, loss of appetite, weight loss, and occasional thoughts of suicide. His life story was filled with a series of losses, abandonment, an absent father, and a physically and emotionally abusive mother. The resident carefully explained to the young man that he could find no evidence to support the diagnosis of ADHD; however, the resident recommended that because of the young man's obvious depression, he immediately start treatment with antidepressant medication and plan to meet with the resident regularly to explore his life story further.

Then the struggle began! The patient insisted that his problem was ADHD and, no matter what the doctor thought, he would not take any medication. The resident said he needed to trust the doctor: "Trust me, I know about these problems and how they are best treated." The student dug in his heels and argued for a diagnosis of ADHD. To further his case, the resident scheduled psychological testing. As expected, it did not reveal ADHD but did show evidence of severe depression. Still unconvinced, the student continued to refuse medication and was erratic in keeping his appointments. In a further effort to convince the student about the diagnosis and recommended treatment, the resident said he was setting up an appointment with a senior consultant. The consultant would be the expert—the patient could trust her expertise. Not surprisingly, the student canceled the meeting. So the resident and I spent the consultation hour talking about his sense of desperation and his distress and frustration with patients who wouldn't listen, wouldn't trust, and wouldn't let you do what needed to be done to save their lives.

This frustration didn't come from a lack of insight into the probable origins of the patient's difficulty. The resident, when he stepped back and thought about it, could give a well-informed explanation for the patient's difficulty in trusting. Given the patient's background of deprivations and loss, he had no reason to trust anyone. But, when the caring and compassionate therapist meets the immovable force of the noncompliant untrusting patient, worry and exasperation often block out reason. If trust is what is needed, it is hard to accept that the patient really can't trust.

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"Look," I said, "think of it this way. You're on one side of a river. On the other side is someone extremely afraid of the enemy troops that are rapidly approaching from behind. He waves his arms at you and cries out for your help. But, when you shout to him to swim across, it turns out he can't swim. That's your patient. He can no more trust (much as he might want to) than the man I described can swim. You have to find ways to coax him into the water and hope that, from such a distance, you can help him learn at least to dog paddle before the enemy arrives."

"That's a fine metaphor" said the resident, "but right now I think I should have chosen internal medicine. Here

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I am—helpless in the face of someone’s illness. He is not so sick that I can forcibly hospitalize him, but he is increasingly miserable and incapacitated. All I can do is stand by patiently, hoping to teach him to swim before the forces of illness destroy him or he drowns! If I had chosen obstetrics or pediatrics, I wouldn’t have these problems.”

“Well, Isn’t it pretty to think so?” I said, quoting Jake Barne’s closing line in *The Sun Also Rises.*

**PATTERNS OF POOR COMPLIANCE**

A look at the studies in the fields of internal medicine, pediatrics, and obstetrics regarding patient compliance paints a very grim picture:

- A study of 192 adolescents with chronic diseases such as diabetes, asthma, and lupus found that overall compliance with treatment or with general instructions took place no more than 50% of the time.
- Patients with hypertension failed to keep follow-up appointments 50% of the time and only 60% took their medications as prescribed.
- Interviews with 100 postmenopausal women revealed that only 61% continued to take their hormone replacement therapy after the first 12 months.
- An investigation among 2,175 men of the relationship of treatment compliance to mortality after a myocardial infarction revealed that patients with poor compliance were twice as likely to have died within a year of follow-up compared to those with good compliance.
- Patients’ patterns of poor compliance despite such statistics are demonstrated in a study of the causes of decompensation in patients treated for chronic congestive heart failure. This study found that, in 47% of the cases, the reason for referral for emergency hospitalization was insufficient compliance with the prescribed treatment.

This is but a small sample of the literature on the subject. We in psychiatry are not the exception when it comes to questions of patient compliance; but we do have an appreciation of the mechanisms underlying compliance problems. Our daily work consists of understanding psychological defenses such as denial, reaction formation, and intellectualization and the conflicts that underlie their formation.

**Encouraging Trust**

As a consultant, what do I tell the anxious resident?

First, in this case, the resident certainly needs to decrease the pressure on himself and the patient. Unfortunately, the patient can’t be rushed into treatment—yes, the patient is miserable, but not yet certifiable, so the therapist is going to have to proceed at a pace the student can handle. This includes gradually building both the real relationship and the therapeutic alliance. Then, like a detective, the resident will have to look for clues to uncover the danger, real or imagined, that is making the patient fearful. The hypertensive patient, for example, may be dealing with very real anxieties which intensify his denial, such as anxious concerns about future physical helplessness, stroke, or death. Does the student have anxieties that are based in reality or anxieties that are more internal and related to developmental experience? Are the patient’s anxieties accentuated by transference? For example, is he longing for a caretaker but at the same time automatically fearful that such a person will abandon him, as did his father, or abuse him, like his mother? Is the student harboring a paranoid delusion somehow related to ADHD? Delusions can’t be argued away, but instead need to be dealt with empathetically. This will hopefully increase the patient’s sense of trust about disclosing other fears and concerns. Does the patient’s obstinate refusal to accept the therapist’s recommendation and his erratic attendance at appointments suggest fears about dependency? If so, the patient needs reassurance that he will be able to maintain his autonomy in spite of making use of the therapist’s expertise. Is this someone with severe obsessive-compulsive characteristics who needs more in the way of explanations in order to feel comfortable?

The very illness that brings patients to treatment may inhibit their ability or freedom to be open and frank about their symptoms.

Yes, it is true that the work of the internist is in some ways different. Diagnosis is not as dependent upon a patient’s open communication, and a lot can be learned by taking a blood pressure, x-ray, or CAT scan. The main tool required to make psychiatric decisions is often the patient’s clinical history, including his or her past and present life story. However, the very illness that brings patients to treatment may inhibit their ability or freedom to be open and frank about their symptoms. There we are, strangers, asking patients to trust us, asking them to tell us about the intimate details of their lives: do they feel like ending their lives? what are the voices saying to them? how much do they drink? do they take street drugs? when they become
angry, are they violent? and so on and so on. At least our knowledge positions us in a much better place than others to understand resistance, to forge an alliance, and eventually to reduce the anxiety that prevents compliance.

In this case, the student finally revealed that his father had died in a mental hospital! Although he knew this was important information to tell the psychiatrist, he had been too afraid to do so. He didn't know what his father's diagnosis had been because no one would ever talk about it. He was very afraid that the psychiatric resident thought that he was "crazy," which in his mind he equated with being like his father and spending the rest of his life in a mental hospital. ADHD was a safe diagnosis. The patient experienced the resident's compassionate concern and encouragement regarding medication as the demands of his mother. She would beat him when he didn't respond as she wished and, at other times, she beat him for reasons he didn't understand. As a result of these real and transference concerns, he had an intensely ambivalent reaction to the resident. He yearned to be able to trust, but had many irrational fears that led him to make and break appointments.

Final Thoughts

The frequency and ease with which we discuss forming a trusting doctor-patient relationship belie the difficulties involved in actually achieving such relationships. Professionals expect to make therapeutic contact easily, at times ignoring the patient's difficulties in this area, and then consider themselves failures when they are less than successful. It takes time to tease apart the subtleties that encrust the psychological make-up of patients. The 15-minute visit, the hurried pace imposed on today's caretakers, the threats to patient confidentiality, are all forces that run counter to the means to provide quality patient care. Our first step is to continue to appreciate the hurdles patients must overcome to reach out to us, the frustrations we face within ourselves in dealing with them, and the battles we have to fight to provide a system of care in which we can practice these principles effectively.

References