Helplessness in the Helpers: Etiology and Management

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LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. Such consultations require the integration of medical and psychiatric knowledge. During their twice-weekly rounds, **Dr Stern** and other members of the Consultation Service discuss the diagnosis and management of conditions confronted. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

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While working as a clinician, have you ever felt completely helpless and thought that you could do nothing to assist your patient? If you have, then the following case vignette and discussion should prove useful.

CASE VIGNETTE

Dr A, a recent medical school graduate, was working on a medical unit when one of the patients, Mr B, complained of chest pain. Rushed into the patient's room by nurses, Dr A saw Mr B clutching his chest and breathing heavily. Unfortunately, Dr A had never met Mr B and had no knowledge of his medical history. However, as the only doctor on site, he was expected to handle the situation.

Dr A clenched his teeth and suppressed his initial impulse to scream out of panic. He started to think about a differential diagnosis. He noted that Mr B was bald and overweight and appeared to be about 70 years old. Dr A suspected that Mr B also had a high cholesterol level and a sedentary lifestyle. Given the report of chest pain, Dr A figured that Mr B might be having a myocardial infarction.

A nurse became impatient with Dr A, who had not given any orders since he walked into the room. She put a pulse oximeter on Mr B's finger. Dr A realized that he probably should have thought of that, but he had not. Dr A noted that Mr B's blood oxygen saturation was 78%. He pondered whether Mr B's low oxygen saturation might be due to something other than a heart attack, such as a pulmonary embolus. Mr B certainly looked short of breath. However, he also looked like a heavy smoker and might be afflicted with chronic obstructive pulmonary disease. Perhaps his oxygen saturation typically ran low (eg, 80%–85%), and it had just dropped a tiny bit. Obtaining an arterial blood gas could have helped differentiate the 2 conditions. Mr B also complained about a squeezing pain that seemed to come from beneath his sternum. Surely, that was more typical for a myocardial infarction than a pulmonary embolism? Mr B gasped and made an agonizing moan. His face contorted with pain and anguish, prompting Dr A to feel a chill travel down his spine. He worried that the end was near.

Two more nurses entered the room. One raised the head of Mr B's bed, while the other administered oxygen to the patient. Mr B began to breathe more easily, although he still complained of persistent pain. The nurses looked at each other, and one of them shook her head from side to side and mumbled. Dr A wondered, "Are they talking about me?" After all, he had not accomplished anything since he walked into the room. He felt both stupid and useless.

Dr A heard someone crying behind him. He turned around and saw a woman in her 60s weeping. Between sobs she repeated, "He's dying, he's dying. . . ." Dr A deduced that she must be the patient's wife. It appeared as if she knew that her husband was about to die. Dr A felt sorry for the wife and wondered whether Mr B was already suffering from some severe illness with a poor prognosis. Maybe it was not worth trying to save his life.

One of the nurses drew some fluid out of a small vial. She turned to Dr A and said something. "What?" said Dr A. The nurse responded, "I said, can I administer morphine?"

"Uh . . . sure," said Dr A. Of course! Morphine! The patient is, after all, in pain. Dr A thought, "Why didn't I think of that?" The nurse

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Clinical Points

- Certain clinical situations (eg, patients and illnesses) can make a caregiver feel helpless.
- Clinicians can overcome their helplessness by dividing an overwhelming situation into its smaller and more manageable components and by understanding the situation with which they are faced.
- By analyzing and interpreting their own psychological reactions, clinicians can often gain valuable insights into their patients.

administered the morphine. By now, more staff (including an anesthesiologist, another doctor, and a cardiologist) had entered the room. Dr A breathed a sigh of relief. He was no longer in charge. However, his experience had taught him a crucial lesson—about helplessness. When presented with an opportunity to act, he found himself paralyzed and dumbfounded. Any doubts he might have had about his own abilities had been confirmed by his lackluster performance and by the negative reactions of the nurses. A vicious cycle of helplessness and insecurity had begun.

WHY MIGHT A PHYSICIAN FEEL HELPLESS WHEN FACED WITH AN ILL PATIENT?

Helplessness comes in different forms. There is the classic "emergency room panic" of the newly minted medical graduate faced with an acutely ill patient. This is the kind of helplessness that struck inexperienced Dr A in the vignette above. However, helplessness is not always associated with panic; it can also be elicited by those who suffer from chronic conditions (such as dementia, stroke, and metastatic cancer).[1] These conditions are indeed incurable and are often difficult to treat; however, this does not necessarily mean that all caregivers will feel helpless. After all, as the old doctor's adage goes (often attributed to Dr Edward L. Trudeau), the job of a physician is "to cure sometimes, to relieve often, to comfort always." If incurable and progressive diseases always produced helplessness in caregivers, then every geriatrician would be in a constant state of psychic paralysis.

CAN HELPLESSNESS BE LEARNED?

A search for additional causes of helplessness might prompt one to look at the groundbreaking work of psychologists Martin Seligman and Steven Maier some 50 years ago.[2] In a famous experiment, Seligman and Maier placed 2 groups of dogs in paired harnesses, with each pair consisting of one dog from group 1 and another from group 2. Dogs in group 1 were subjected to painful electric shocks, which the dogs could stop by pushing a lever. The dogs in group 2 received the same shocks as the dogs in group 1, but their levers did not stop the electric shocks. Thus, the group 1 dogs had some control over the painful stimuli, whereas the dogs in group 2 did not. In the second phase of the experiment, Seligman and Maier[2] utilized a shuttle-box apparatus, in which the dogs could escape electric shocks by jumping over a low partition. The group 1 dogs quickly jumped out of harm's way, while many of the group 2 dogs made no attempts to escape; instead, they simply lay down and whined, displaying signs associated with clinical depression.[2] Subsequent experiments have also shown increased plasma cortisol levels in dogs subjected to uncontrollable shocks.[3] The experience of these dogs taught the researchers that when one lacks control over his or her circumstances there is no point in trying to escape the painful stimulus. Seligman[2] named this phenomenon "learned helplessness." Due to ethical concerns, the study they performed could not be replicated in humans. However, similar studies, in which people were exposed to inescapable noise or faced with an insoluble problem, have demonstrated that humans are no less susceptible to learned helplessness than are animals.[4]

HOW IS LEARNED HELPLESSNESS MANIFEST IN THE GENERAL POPULATION?

Frequently, learned helplessness is associated with depression[5] and difficulties with social interaction.[6] Studies have shown that people who are depressed or who cite helplessness in social situations are generally viewed poorly by others.[7] This derision reinforces the individual's negative thinking and creates a vicious cycle of rejection and insecurity. At times, negative patterns of thought begin in childhood.[8] For example, a person who struggled with math as a youth might later in life feel unable to solve any mathematical dilemmas, including those that are well within his or her grasp. One can thus imagine a similar scenario involving a caregiver with a history of clinical failures falling prey to negative thinking.

WHAT IS THE RELATIONSHIP OF COUNTERTRANSFERENCE AND EMPATHY TO HELPLESSNESS?

In the psychoanalytic literature, *transference* denotes an unconscious redirection of feelings from one person or object to another.[9] For example, if a doctor reminds the patient of his or her abusive father, then the patient might transfer negative feelings about the father toward the doctor. The term *countertransference*, on the other hand, is used to describe the unconscious, emotional response of a caregiver to a particular patient.[10] This response is dependent on the caregiver's own experiences and unconscious feelings and can impact the objectivity and effectiveness of the treater. For example, if the physician feels helpless while trying to get his or her own child to work harder in school, a patient who is reminiscent of that child might evoke a sense of helplessness in the physician. These kinds of unconscious responses should be separated from those resulting from mere empathy (sharing in the distress of another person) or sympathy (concern for the well-being of another person).[11] For example, a doctor who despairs while telling a tearful patient about a malignant tumor found on an x-ray is most likely experiencing empathy, rather than a countertransference reaction. In critical situations, however, even healthy psychological responses sometimes need to be suppressed so that the doctor can do his or her job (Table 1 provides a summary of these concepts).

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Table 1. Definitions of Terms Relevant to the Doctor-Patient Relationship

Phenomenon	Definition
Transference	The unconscious redirection of feelings from one person or object to another
Countertransference	The unconscious, emotional response of a caregiver to a particular patient
Empathy	Sharing in the distress of another person
Sympathy	Feelings of concern for the well-being of another person

WHAT OTHER FACTORS ARE ASSOCIATED WITH HELPLESSNESS?

Regardless of whether a helpless physician is the victim of learned helplessness, countertransference, poor training, or simply an especially difficult clinical situation, he or she is also likely to be at the mercy of psychological stressors. Prolonged stress induces a persistently elevated anxiety level and puts the individual in an elevated cortisol state,[12] similar to that associated with learned helplessness. The extent to which a physician is susceptible to job stress or helplessness depends on several factors, one of which is personality type. Doctors who display high levels of "negative affectivity" (a trait resembling neuroticism/vulnerability) and/or "reality weakness" (perceptions and ideations on the borderline between reality and fantasy) have been shown to be sensitive even to moderate or low levels of stress.[13] In addition, physicians who display high levels of idealism and commitment are most apt to "burn out," as they often fail to live up to their own professional ideals.[14] One study[13] indicated that the emotional pressures associated with patient interactions might play a larger role in producing stress in doctors than other more commonly reported factors (such as long working hours or sleep deprivation). Everyday experiences (eg, not being able to cure every disease, not being able to make everyone happy) can be regarded by some as crushing defeats, creating a vicious cycle of perceived failure and negative thinking. Such distress can be compounded when a physician confronts an illness that he or she is ill-prepared to manage, such as a psychiatry resident who encounters a patient with a myocardial infarction.[15]

WHAT CAN PROVIDERS DO WHEN FACED WITH HELPLESSNESS?

A reasonable starting point is to look at the risk factors for helplessness. Questions might include, "Do I work too much or sleep too little? Do I have unreasonable expectations as to my performance as a physician? What about other important stressors (such as relationship issues, financial worries, or recent deaths in the family)?"[13] If a nonclinical stressor lies at the heart of the helplessness, then focusing solely on one's job situation might not solve the problem.

Before delving more deeply into the psychological issues involved in helplessness, the clinician should also ask, "Is my helplessness merely a logical consequence of a lack of training or knowledge?" For example, "When was the last time I received advanced cardiopulmonary resuscitation training?" Sometimes, as doctors subspecialize, they forget how to deal with certain types of acutely ill patients. This cause of helplessness has a solution—learning (eg, reading and participating in a refresher course).

What about countertransference (ie, the physician's response evoked by the patient)? Although primarily a concept associated with psychiatry and psychoanalysis, doctors in other fields are not immune to countertransference reactions. "Blind spots" can be avoided when a questioning attitude toward one's own feelings and motives is maintained. Sometimes, countertransference reactions can even be useful, in the sense that they increase our self-knowledge and can provide a kind of subconscious means of diagnosis. For example, a doctor who feels helpless when confronted with a patient who reminds him of his own child might ask himself why he feels this way. What was it, specifically, about the patient that caused this feeling? By taking a step back and analyzing this reaction, the doctor could have mitigated his negative response and gained valuable insights about the nature of the patient.[16] Ideally, one could use the multidisciplinary team to clarify and discuss the various ways in which a certain patient might influence caregivers. If these approaches prove insufficient, then the physician might benefit from individual psychotherapy to map his or her psychological weaknesses and susceptibility to countertransference.

As for learned helplessness, or the development of negative thought patterns over an extended period, some techniques used in cognitive-behavioral therapy have proved helpful. Seligman[17] hypothesized that learned helplessness could be overcome by helping people change their explanatory styles in ways that would promote "learned optimism." This shift of paradigms from negative to positive is best accomplished in a piecemeal fashion by breaking the anxiety-producing situation into smaller and more manageable components.

CASE VIGNETTE: PART 2

Dr A had a problem. When confronted with a difficult clinical situation, he felt paralyzed and helpless. How can Dr A be helped?

Dr A had a tendency to over-theorize, a trait that is common among recent medical graduates with little clinical experience. Rather than focusing on Mr B's acute symptoms, Dr A started to analyze risk factors in the hope of establishing the final diagnosis. Since Mr B's symptoms were somewhat ambiguous and consistent with at least 2 different disorders, Dr A got stuck trying to make an accurate diagnosis with limited information.

Dr A was also overwhelmed by his situation—by the severity and nature of the symptoms, by the unexplained drop in oxygen saturation, by the hostility of the nurses, and by Mr B's upset wife. All of these powerful forces coalesced to induce information overload; he became paralyzed trying to put the data into context. Dr A also found himself too bothered by his empathy for Mr B, whose agonizing groans

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made Dr A gloomy and dysphoric. He was also affected, as well as distracted, by Mr B's wife, as he wasted time and energy trying to figure out a deeper meaning for her despair. Finally, as Dr A tried to negotiate his way out of his paralytic state, the nurses' negative reactions confirmed to him that he was, in fact, useless. Rather than trying to prove the nurses wrong by springing into action, Dr A analyzed their reactions, and pondered the various ways in which they might find him incompetent or objectionable. He thus entered a vicious cycle of helplessness and negativity, which persisted until 2 senior colleagues brought him out of his misery.

HOW CAN HELPLESSNESS BE MANAGED?

Several strategies exist for managing helplessness; however, the best approach often involves dividing the problem into its components. In the case of Dr A, whose helplessness sprung from his inability to manage a complex situation, this method would seem particularly appropriate.

The main problem faced by Dr A was that Mr B had acute chest pain. The 2 most likely causes were (1) an acute myocardial infarction or (2) an acute pulmonary embolus. What can be done to cure these conditions? The answer is, of course, a great deal. In the case of a myocardial infarction, coronary angioplasty can open an occluded vessel (or vessels) and rescue myocardium at risk. In the case of a pulmonary embolism, the administration of heparin or thrombolysis can be life-saving. However, each of these maneuvers requires at least some degree of preparation, and this raises the following question: "What could Dr A have done to cure the condition *at that very moment*." Here, the most likely answer is nothing. Upon first seeing Mr B gasping for air, Dr A should have deferred any considerations about etiology and simply focused on the ABCs (ie, management of Airway, Breathing, and Circulation).

The same can be said for Mr B's hypoxemia. The known causes for hypoxemia are myriad, including primary cardiac problems, ventilation-perfusion mismatching, pulmonary shunts, and diffusion impairments. However, since Dr A had no quick and easy way of figuring out the cause of the hypoxemia, he would have been better off not concerning himself (initially) with questions of etiology. Instead, he could have confined himself to the basic maneuvers of having the patient sit up and giving him some oxygen. What about the pain? Again, since Dr A had yet to discover the cause of the pain, all he could do at the moment was relieve it. This relief could have been accomplished by giving Mr B a narcotic (eg, morphine) and evaluating his response.

What about the negative attitude of the nurses that caused Dr A to doubt his own abilities? Perhaps they didn't like him and, if so, why not? Maybe they didn't like him because he sounded rude in the past when he asked them to retrieve some files from the basement. Or, maybe they didn't like him because he was overweight or because he was of a certain ethnicity or because he spoke with an accent. Maybe the nurses were subject to transference; that is, maybe they didn't like Dr A because he reminded them of a prior year's intern. The only relevant question at the moment, however, should have been, "What can be done about it *right now*?" The answer would have been obvious, nothing. Even if Dr A could have figured out the reasons why some of the nurses didn't like him, there was nothing he could do about it right then and there. In other words, he was better off ignoring it all together. The same can be said for the reaction of Mr B's wife, whose anguish and despair were quite natural, considering the circumstances. Just as a physician must be able to feel and show empathy, he or she must also learn to keep such emotions in check. An excess of empathy on the part of a physician can lead to increased levels of stress and "compassion fatigue," potentially exacerbating feelings of helplessness.[18] Having no way of alleviating the wife's distress at the time, Dr A would have been well advised to disregard it.

Had Dr A completed this mental exercise, rather than letting himself be overwhelmed by the drama that surrounded Mr B's deterioration, he most likely would have managed the situation more effectively and avoided a vicious cycle of failure and self-doubt.

Whereas the scenario of Dr A illustrates the helplessness and panic of an acute situation, it does not touch upon the sinking feeling of helplessness one might experience when confronted with a chronic, incurable condition. The best approach in these situations is, however, quite similar to that described above and goes back to the famous maxim often attributed to Dr Edward L. Trudeau. Like Dr A, the caregiver should start by disregarding the things that can't be done (eg, curing the dementia secondary to Alzheimer's disease) and focus on what can be done (eg, offering guidance, support, symptomatic relief). This approach should bring about a shift of paradigms from negative to positive, hopefully avoiding the trap of helplessness.

CONCLUSION

Helplessness in physicians has many potential causes, including negative thought patterns, susceptibility to countertransference and similar unconscious responses, lack of training, and a host of psychological or physiologic stressors, work-related and otherwise. These stressors can be confronted in a variety of ways.

Doctors who suffer from bouts of helplessness when faced with certain patients or illnesses can often benefit from applying some of the techniques used in cognitive-behavioral therapy. For example, by dividing an overwhelming situation up into its various elements (as in the vignette), a caregiver can avoid getting trapped in negative thought patterns. Needless to say, this is easier said than done. As the plasma cortisol level rises and the fight-flight response is initiated, one can get carried away by the totality of a situation, rather than remaining focused on its components. As a means for combating psychological problems (such as anxiety, phobias, and learned helplessness), however, the cognitive-behavioral model has time and time again proved effective for a wide variety of patients, including, presumably, practicing physicians.

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