INPATIENT PRACTICE

Humor and the Therapeutic Alliance

The ability to understand and create humor is a high-order cognitive function that might elude some patients with mental illness. However, several studies have shown that very often, psychiatric patients are able to detect and appreciate humor.

In one study, patients with schizophrenia were no different from controls in appreciating humor by identifying funny moments in four silent slapstick comedy film clips. However, the investigators did find that the patients were less sensitive than controls in detecting humor (Psychol. Med. 2008;38:801-10). Another study found that patients with bipolar disorder were able to find humor in captionless cartoons while they were in remission (J. Nerv. Ment. Dis. 2007;195:773-5).

Given the ability of psychiatric patients to discern and appreciate humor, can it be used to help advance their treatment?

This month, CLINICAL PSYCHIATRY NEWS speaks with Dr. William B. Hunter about the value of humor on the unit. Dr. Hunter is an attending psychiatrist on the inpatient psychiatric service at Woodhull Medical Center in Brooklyn, N.Y., and was the featured psychiatrist for an Inpatient Practice column published 2 years ago on using Suboxone (CLINICAL PSYCHIATRY NEWS, January 2007, p. 54).

Clinical Psychiatry News: Is there a place for humor in the care of psychiatric inpatients?

Dr. Hunter: As in religion, humor in medicine is a delicate matter, often better partly ignored, if not left alone altogether. However, humor also forms and defines many things human, and working with all things human is the essence of good medical practice.

CPN: Are you suggesting that psychiatrists should be prepared to kid around with patients? Is it possible that establishing this kind of rapport could prove counterproductive to treatment?

Dr. Hunter: It really depends upon the patient. In a recent essay that appeared in the health section of the New York Times (Nov. 18, 2008; p. D5), Dr. Benjamin Brody, a psychiatry intern, raised the question of whether to laugh at a patient's joke. Whether to laugh appears to be more a function of the physician's level of comfort in an emotionally charged situation than a matter of what is right or wrong. A solid foundation of self-knowledge will allow the physician an immediate grasp of the source of the patient's humor, and the physician's response—whether to laugh or not—can be supportive and therapeutic. This sort of empathy should be the essence of every physician-patient transaction, and I believe all physicians strive for such empathy.

CPN: How can humor be used to help the psychiatrist advance the treatment?

Dr. Hunter: Psychiatry (and probably medicine in general) is moving more and more toward checklists. This is certainly true of inpatient psychiatry, where checklists may account for the entirety of the psychiatric diagnostic work-up of each patient. Forms with checklists may be long and comprehensive. We learn to absorb large amounts of data about the patient and reformulate the results as a comprehensive treatment plan. But despite all of the data we have, too often the patient's story—which is crucial to understanding the person as an individual—is missing.

CPN: Are you suggesting that some reference to humor be added to these checklists?

Dr. Hunter: Perhaps. I have never seen a treatment plan in which humor was assessed. And I am not speaking of telling jokes here. Rather, I believe it is true that most of our patients have a sense of humor. Identifying the rare patient who has none would itself be important.

CPN: What aspects of the patient's sense of humor would help in your assessment?

Dr. Hunter: It would be useful to assess the availability of the individual's sense of humor. Then we should also look at the quality of that humor: Is the sense of humor dry? Does it tend toward sarcasm? Is the humor such that it reveals a degree of self-reflection, or is it generally at the expense of others? I do not believe that humor on its own merits will lead to a refined diagnosis; [an assessment of] the quality of a patient's anxiety would be superior, for example. However, I do believe that recognition of the presence and quality of a patient's sense of humor and the degree of availability of that humor in a treatment setting would promote a vastly stronger therapeutic alliance.

CPN: You seem to be suggesting that humor can be used to get beyond the surface in psychotherapy with patients.

Dr. Hunter: Absolutely. The physician's understanding of the patient's sense of humor allows that physician a marked increase in depth and dimension of communication with a given patient. By being on the same empathic "wavelength" as the patient, the physician has greatly enhanced capacities for thorough exploration of treatment options [and the] empathy to lend the patient emotional support through rough places in the progress of treatment.

Understanding and appreciating an individual's sense of humor allow the physician a window into the soul of that particular patient. Such knowledge from this window is a part of the provenance of the physician. The assessment of the availability and quality of an individual patient's pool of humor can allow us to be more comprehensive in our provision of care, certainly in a qualitative sense.

We will then know and appreciate each patient's story in a way that leads to more effective and supportive treatment. ■

By Gina L. Henderson, Publication Editor. Send your thoughts and suggestions to cpnews@elsevier.com.

Warning Signs Can Predict Psychosis-Motivated Assaults

BY SUSAN LONDON
Contributing Writer

SEATTLE — Certain symptoms that are present up to month in advance herald psychosis-motivated assaults by psychiatric inpatients, according to a study reported at the annual meeting of the American Academy of Psychiatry and the Law.

Research on assaults by inpatients has focused on static factors and has not differentiated among assaults based on their motivation, lead author Dr. Cameron D. Quanbeck, a psychiatrist at the University of California, Davis, said in an interview.

In the retrospective study, he and his colleagues sought to identify dynamic factors—transient symptoms, behaviors, and situations—that predicted assaults specifically motivated by psychosis.

The investigators assessed the presence of symptom clusters among 26 long-term psychiatric inpatients at the Napa (Calif.) State Hospital (the state's largest forensic hospital) who had schizophrenia or major psychotic disorder, and had assaulted another patient or a staff member.

Nurses' notes were reviewed for the 6-month preassault period and a 6-month historical control period during which the patient had been clinically stable.

The symptom clusters assessed were psychomotor agitation; hostility/angry affect; staff intervention (e.g., seclusion, restraint); paranoid delusions; verbal aggression/attacks on objects; disinhibited, impulsive behaviors; internal preoccupation; anxiety; and depressed, isolative behavior.

Results showed that all nine symptom clusters were significantly more common in the preassault period than in the control period (odds ratios, 2.9-6.9), Dr. Quanbeck reported.

Within the preassault period, six of the clusters were more common in the month before the assault, compared with the preceding 5 months.

Inpatients were more than five times as likely to require staff intervention in the week before the assault, compared with the preceding 3 weeks.

Specifically, patients were two to three times more likely to have psychomotor agitation (odds ratio, 1.8); hostility/angry affect (1.7); paranoid delusions (2.3); verbal aggression/attacks on objects (2.7); disinhibited, impulsive behavior (2.6); and the need for staff intervention (3.2) during this month.

Some of these symptoms became even more common and a new symptom (internal preoccupation) appeared as the assault grew yet closer, Dr. Quanbeck noted.

Patients were two to five times more likely to have psychomotor agitation (odds ratio, 3.2), hostility/angry affect (3.2), and internal preoccupation (3.2), and to need staff intervention (5.6) during the last week before the assault, compared with the preceding 3 weeks.

An additional study finding was that none of the patients were taking clozapine (Clozaril) in the preassault period, compared with 40% in the control period. "This suggests that Clozaril is a very effective medication for controlling aggression and the symptoms of psychosis," Dr. Quanbeck said. The drug has some serious adverse effects, he acknowledged, but they may be an acceptable tradeoff for preventing violence.

The study's findings add to previous research on predicting violence among inpatients, most of which has focused on the day before an assault occurs, Dr. Quanbeck said. "This gives you a longer time frame in which to clinically intervene," he explained.

In light of the complexity of human behavior, patterns of symptoms are likely more useful than individual ones in predicting assaults, he commented.

"Monitor these patients. Look for this pattern of symptoms that shows up (early)," he recommended. And if patients do become more symptomatic, reevaluate their medications and consider possible interventions (a medication revision, psychotherapy, and stepped-up observation).

"If you can intervene in the preassault period, maybe the assault will not happen," he concluded.

Dr. Quanbeck reported that he had no conflicts of interest in association with the study. ■