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CHRONIC PATIENTS' POWER GAMES AND THE PROPER SETTING OF LIMITS

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The author found that the chronic mental patients at a state hospital aftercare clinic brought for consultation because of lack of therapeutic progress were all engaged in manipulative power games with the staff. The most common games involved medication, attendance and punctuality, and misbehavior. Defiance was the major motive: the patients' ability to frustrate and triumph over the staff created subtle "highs" for them in otherwise bleak lives. The staffs were usually unaware of the games. When they recognized them, stopped them effectively, and focused therapeutically on helping the patients examine and change their maladaptive ways of acting and thinking, improvement began to occur. Power games are important in other aspects of psychiatric practice; examples are given.

Many chronic mental patients play manipulative power games which are unrecognized by those treating them. Despite thirty years of practice in many settings, I had not appreciated the importance of this phenomenon until I began serving as consultant to several day hospitals/aftercare clinics at a large state hospital. One of my responsibilities was to lead staff conferences to discuss patients whose treatment seemed to be at an impasse. I found that

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PSYCHIATRIC QUARTERLY, Vol. 62, No. 1, Spring 1991
033-2720/91/0300-0067$06.50/0

all of these patients were engaged in such games—all of them deliberate and many of them provocative—and that the staff completely failed to recognize them. The staff's writing such games off as "sick" removed responsibility from the patients for their behavior and increased the magnitude and intensity of the games.

TYPES OF CLINIC GAMES

Three types of game could be seen in the clinic. They concerned (1) medication, (2) clinic punctuality, attendance and activities, and (3) behavior outside it, sometimes bordering on the criminal.

Medicational games involved the psychiatrist primarily. The patients would complain that they were experiencing too many drug side-effects, or were getting the wrong medications, or were being given too much or—rarely—too little. The psychiatrist spent all his time with them discussing these issues, which almost never got resolved. This left him little or no opportunity to examine other aspects of the patient's life: what, if anything, he was doing to change his habits and behavior, to socialize better or to find worthwhile activities. Getting patients involved in useful and satisfying activities, preferably under the care of one knowledgeable and trusted psychiatrist, until they attain their maximal level of functioning is central to the effective treatment of chronic mental patients.[1,2] This is a long slow process, usually lasting months or years.

Psychiatrists who overstressed the clinical importance of medication, and minimized the importance of counseling patients, got caught up relatively easily, and sometimes even eagerly, in these medicational games. Their efforts to find the ideal psychopharmacological treatment never succeeded; one clinic psychiatrist reported that he had been treating a patient for three years and "all I've given him is tardive dyskinesia."

Clinic attendance games involved the staff more than the psychiatrist. The patient might start coming late. Or he might demand to be allowed to arrive much later than the rules required. He would give insomnia, anxieties or other difficulties as his reasons for the actual or proposed lateness. But once he was permitted to arrive one hour late, he would soon be asking about two. Or he might ask to leave early, to take a longer lunch, or to get other types of special treatment. When the staff reached the end of its patience, the psychiatrist would frequently be called. Too often, his only suggestion would be a medication change—adding medicational games to the attendance games already being played.

Power games involving behavior outside the clinic were more difficult to handle and socially more dangerous. One young patient pilfered candy from a nearby store. When its owner threatened to call the police, the staff pleaded that she was too ill to be responsible for her behavior, and persuaded the owner to accept payment for the stolen candy—which the staff itself donated. This patient's continuing thefts represented one of the impasses presented to me. Despite the protests of several staff members, I insisted that she be considered responsible, and that the police should be called if the thefts continued. They then stopped immediately.

POWER GAMES IN THE COMMUNITY

Patients can use power games rationally to attain rational goals. When the Supplemental Security Income (SSI) checks of a man disorganized by the extensive use of hallucinogenic drugs were suddenly stopped for no known reason, he said, "first I'll go to an emergency room and act crazy. Then I'll tell the psychiatric resident that I'm hearing voices that tell me to kill a psychiatrist. That'll get me into the hospital and then I'll get the social worker there to fix my SSI." He had learned his strategies from repeated, if brief, stays in mental hospitals.[3]

Foolish but nevertheless understandable "principles" can be used to rationalize power games. An ex-patient decided to follow and annoy women wearing expensive fur coats in a popular New York City shopping area. The ex-patient yelled at them and accused them of a host of misdeeds: crimes against humanity, conspicuous consumption, wretched excess, and general unfairness. Repeated brushes with the law followed. (Since the ex-patient was a woman, her former-patient status usually led to dropping the charges and releasing her. If the ex-patient following women around had been a man, however, jailing or hospitalization would have been much more likely.)

This woman returned to her pestering as soon as she was released. She knew that her behavior broke the law, but claimed

she was acting on a "Robin Hood" principle–defending the poor against the rich by attacking the rich. She also denigrated the legal system as "yet another example of economic injustice and therefore worthless," and which she therefore did not need to obey.[3] But her real motivation was similar to the games-players at the clinics: obtaining a sense of power and personal value from challenging authority and getting away with it.

Patients engaging in provocative power games can paint themselves into undesirable corners. An adult home mental patient considered herself a great believer in personal freedom and questioned all the house rules she was required to obey. Many were quite trivial and arbitrary, although some were perfectly sound, but she opposed regimentation on principle and clearly enjoyed the combat. The home's owner finally evicted her, which was quite difficult given the eviction laws and her intelligence. A few years later she was seen barefoot and dressed in a plastic garbage bag, rummaging through trash cans on Madison Avenue [New York City], a good 20 miles from the home.[3]

HANDLING THE GAMES: FIRM LIMITS, BUT NOT HARSH

A bright, hopeless, 36 year old single former teacher, holder of an M.A. degree, kept himself emotionally alive by challenging those about him, especially at the clinic. He had been in psychiatric treatment for ten years, beginning with an initial two month hospitalization for wildness and anger, and had had several subsequent rehospitalizations. He was given 20 electroshock treatments during one of them. The clinic had given him a host of different medications during his three years there but none had done much good. He continued insisting vehemently that he wanted to sue the government for back pay because it had discriminated against him in refusing him jobs on account of mental illness–even though the staff had repeatedly told him that his behavior was still too crazy for him even to consider working.

His customary defiant and provocative ways–on both sides of the permissible–were illustrated by his "testing the limits" during his initial interview with me. Because I was a few minutes late, he demanded-permissibly-that I apologize. I did. Then he insisted

impermissibly that I leave the conference room to talk with him alone. I refused and he got angry. He hoped to triumph over me again–he saw my apology as his victory–but I stood firm. Instead, I used the interaction to emphasize to the staff the importance of setting and keeping strict limits with such demanding patients. When I saw him again some weeks later, he seemed less demanding and had started discussing involvement in a rehabilitation program with the staff.

A young man hospitalized in a state hospital ward engaged in a different type of game. During the regular psychiatrist's vacation, I was covering the ward, which held both men and women, most of whom received large doses of medication. This man, who got relatively little, easily persuaded many of the confused women to have sex with him. The nurse asked me to speak to him and I warned him to stop. When I returned a week later, the nurse told me she heard he planned to assault me when I saw him, and expected then, as was usual, to be transferred to another ward. I watched his hands very carefully when I talked to him again. Before he could move them, I assured him that if he laid one finger on me, I would personally swear out a warrant for his arrest and guarantee that he would go to jail. His hands remained in his lap and he was discharged two weeks later. If criminal behavior is involved in patients' games, legal sanctions, or the real threat of them, may be necessary to prevent the criminality from continuing and even worsening.

POWER GAMES WITHIN FAMILIES

Similar power games occur between patients and those they live with. Family members often aggravate the problem. Many marriages and families have been destroyed in this way by children labeled "mentally ill," both young and adult, because they are supposedly not responsible for their actions. They can end in intrafamilial homicide. Considerable therapeutic tact and skill is necessary to heal such deliberately created breaches.[1] But a hopeless, seemingly helpless patient's ability to provoke these situations demonstrates his power, at least to himself.

A provocative young male patient defied his parents by bringing beer into the house. His angry father ordered him out and told him

to find his own place. His mother ignored the violation of agreed-on house rules, sided with her "sick" son against her husband's fury and the battle escalated.

Defining people engaged in misbehavior, including power games, as "mentally ill," and therefore failing to set limits upon them, not only impedes them from regaining appropriate behavior patterns but encourages more misbehavior—the opposite of the handling of the woman who pilfered candy or the man having sex with the female patients. The consequences can be tragic.

In Philadelphia, Maggie Phillips and her disabled husband fled the violent rages of their mentally ill son who refused all treatment.[4] They left their three bedroom row house to him and moved into Maggie's parents' small apartment. He set fires on the lawn, put up obscene posters, removed most of the doors, bashed in the gas range and stripped the house of all its wallpaper. No legal actions were taken.

On the contrary, Maggie brought him food, replaced the windows he broke and vainly continued to seek treatment for him. After he smashed the front door and downstairs windows of the house, breaking the sashes as well as the glass, the police took him to a mental health center which refused to commit him because nobody had *witnessed* him destroy the house. Only when he became enraged at the center, and tried to destroy its glass front door, did it finally admit him. After a brief period of treatment, it released him without follow-up—an even greater danger than before. The Phillipses never dared return to their own home. Young Phillips was one of many never-previously-violent individuals described by Isaac and Armat[4] who became dangerous, and even homicidal, after "mental illness" repeatedly prevented limits from being set on their mounting misbehavior.

PATIENTS' MOTIVATIONS FOR POWER GAMES

Successful handling of patients' power games requires an understanding of why they engage in them. Many chronic patients anticipate little or nothing good ahead of them and therefore live almost entirely for the present. Pleasure at the moment becomes more important than anything an uncertain future might bring.

Domination or triumph over others, and over authority itself, is a major source of pleasure for many of these hopeless and demor-

alized people. Such defiant conquest gives them a quick, intense "kick"—like that obtained from drugs such as cocaine. The possible harm such victories might do to their treatment do not concern them because they expect nothing from it anyway. Indeed, if, like the woman who harassed the fur-coat wearers, they have made the games a matter of political or religious principle, or say they have, inconsistent limits will usually aggravate their defiance. In some traditions, martyrdom for the faith is one of the paths to heaven.

Mental patients do not usually seek to conquer by doing physical harm to others since the police would almost certainly be called. But subtle, psychological conquest, especially over authority figures, can yield considerable, often surreptitious, pleasure. Each time these patients successfully manipulate someone, especially if he is in authority, they feel good for the moment. "Conning" anyone on the clinic staff has this effect but deceiving the psychiatrist, at the top of the organizational structure, can yield particular satisfaction.

CONCLUSION

Demoralized people—chronic mental patients and some criminals—play power games with those around them in order to get immediate psychological "kicks" from their "victories." Recognizing this very common process, a major cause of therapeutic impasse in chronic mental patients, enables one to treat these patients more effectively. Their games must be firmly stopped or they can otherwise mushroom into unrestrained criminality. Patients must be helped instead to engage in useful and satisfying activities which will strengthen and restructure their habits, capacities and skills.

REFERENCES

1. Lehrman NS: Effective psychotherapy in chronic schizophrenia. American Journal of Psychoanalysis 42: 121-131, 1982.
2. Lehrman NS: Whatever happened to continuity of care? The Psychiatric Times (in press). (Sept. 1981)

3. Johnson AB: Out of Bedlam: The Truth about Deinstitutionalization. New York, Basic Books, 1990.
4. Isaac RJ, Armat VC: Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill. New York, Free Press - Macmillan, 1990.

Psychiatric Quarterly

VOLUME 62, NUMBER 1, SPRING 1991

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