"Filled With Desperation": Psychotherapy With an Insanity Acquittee

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The question could have been posed by any patient: a depressed suburban housewife, a melodramatic college student, or a homeless drug addict about to hit rock bottom. On that day, it was posed by J.M. (not his real initials), my patient of about 5 months, during our weekly psychotherapy hour on the maximum-security inpatient unit of the state hospital. It was a serious question, and it had the effect of immediately snapping me back to attention after my interest had drifted away from J.M. to the details of our dreary surroundings. Suddenly, I didn't care that we were sitting on oak-and-green-vinyl chairs in a room filled with relics from an era long forgotten: a television with manual dials, large plastic plants, and a box of cassettes featuring the greatest hits of the 1980s. I didn't notice the disinterested staff members milling about nearby or the faint screaming that was audible from a few doors away. In that moment, all I saw were J.M.'s hooded blue eyes peering expectantly back at me from across the table, waiting for me to answer the question.

"Doctor, do you know what it's like to be filled with desperation?"

"I think I do," I replied. He nodded and accepted this without demanding any further explanation. He did not seem bothered by the brevity of my response, nor did he seem to sense the hesitation with which it was offered. The tension of the moment passed, and J.M. spent the remainder of the session talking about his frustrations with life at the state hospital. The crisis was averted.

I considered the moment a near-miss, an incident in which J.M. came dangerously close to figuring out how little I actually did understand about his experience of the world. He was a complicated patient, and I had only just begun to piece together the intricate puzzle of his life. I had been assigned to be J.M.'s therapist as part of my fellowship in forensic psychiatry, and he was presented to me the way most difficult patients always are: "a great training case." Although I was excited to provide psychotherapy to an insanity acquittee, particularly since this experience is uncommon in forensic training programs, I was apprehensive about encountering the new challenges that would inevitably come with such an unusual patient population. Was a PGY-5 resident really ready to undertake this task?

J.M. was a middle-aged man who had spent over 20 years in the maximum-security psychiatric hospital after being found not guilty of murder by reason of insanity. The first time we met, it was clear that he suffered from a psychotic disorder, as he had many of the stigmata of chronic mental illness: a disheveled appearance, a paucity of spontaneous movement and speech, and a general "oddness" about him. He was friendly enough, and he seemed genuinely excited to work with an individual therapist, as this was an opportunity afforded only to a few patients at a hospital where group and milieu therapy were much more common. And so we began our work together. As is

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often the case in therapy, we didn't know exactly what the work was or where it was going, but we were committed to finding out together.

In the beginning, what I knew of J.M.'s crime came mostly from reading his chart. He had a history of repeated hospitalizations for schizophrenia and polysubstance abuse, and he had stabbed a fellow group-home resident to death during a psychotic episode. J.M. himself rarely talked about the incident, and when he did, his speech typically had a rehearsed quality to it. "I took a person's life, committed a crime, and that's a very serious thing. I'm told it's because I have a tendency to become irritable when decompensated. It's the drugs and my illness!" I could tell that 20 years of group therapy had taught him to say these words with ease. He had become a professional patient, and talking about the crime was all in a day's work.

Despite the dramatic nature of the crime and a natural tendency to want to explore it, J.M. and I focused our attention in therapy on a different issue. His attending psychiatrist requested that we work on building social skills in preparation for his upcoming transition out of the hospital and into the community, as he was known to be a loner and somewhat socially awkward. This was consistent with J.M.'s own wishes for treatment, as he considered the crime in the past and wanted to focus on making his life better in the present. He quickly identified his main problem as a lack of social relationships, and he asked my help in trying to make friends on the unit. He stated his problem succinctly: "I just don't understand why I can't get close to people!"

On the one hand, J.M.'s difficulty with intimate relationships seemed like a garden-variety problem that most psychotherapists could handle with ease. Reasonable therapists might debate whether to take a cognitive-behavioral approach or one that was more unstructured and psychodynamic, but no one was likely to label this an impossible or even particularly unusual problem. On the other hand, I was acutely aware of how far outside the norm J.M.'s life experiences had been, and I had some anxiety about trying to bridge a gap so enormous. I had worked with patients from various cultural, socioeconomic, and educational backgrounds before, but I was still early in my career and had a limited therapeutic repertoire. I had never tried to treat anyone accused of murder.

For the most part, treating J.M. was much like treating any other patient. We worked on some basic concepts of social skills training—interpreting facial expressions, grooming adequately, making polite conversation—at the same time we were exploring J.M.'s isolation and desire for intimate relationships. He was genuinely very lonely, and at times he was quite articulate when expressing his frustration about this. It was in the context of this frustration that he asked me the question, "Do you know what it's like to be filled with desperation?" Although J.M. moved on quickly after I replied, the question haunted me for days. Did I know what it was like to be filled with desperation?

My initial response to the question was an easy, "Of course." I had been a teenager once, and I had certainly experienced my share of gut-wrenching moments. But still, when the question was asked by J.M., the "desperation threshold" seemed higher, and I wasn't sure anymore that I met it. Could I really compare my teenage dramas to the despair of a man who had spent 20 years in a psychiatric hospital? Could anything I had endured even come close to the kind of desperation that drives a person to kill another? Could I really look this man in the eye and tell him that I understood anything about the kind of emotion he was describing? I feared that I couldn't. Over the next few weeks, I grew more and more pessimistic about my therapeutic relationship with J.M. Sessions went by without much progress, and I started to hear the familiar refrain of failed therapies echo in my head: "He's just too impaired, too limited, too psychotic for therapy. He's untreatable." The winter dragged on, and so did my meetings with J.M.

Then one day, just as the spring flowers had begun to bloom, he surprised me. We were nearing the end of a session, and I said to J.M., "It's about time for me to go." He nodded and said, ever-so-simply, "I wish you didn't have to go. I wish you could stay here always, and we could take walks outside together."

It was such a sweet, simple sentiment that was said so casually, and yet it seemed impossibly profound to me. Even after I left that day (after muttering something unintelligible and practically stumbling out the door), I repeated J.M.'s words over and over to myself: "I wish you could stay here always, and we could take walks outside together." How was he able to say them so easily, as if expressing that kind of emotional desire were the most natural thing in the world?

I talked to my supervisors about the incident, and they responded with helpful, if somewhat predict-

able, advice. We had long discussions about transference and the possibility that J.M. was developing a crush on me. This transitioned into a discussion about the risk of working with patients with histories of violence, and I was urged to be cautious and protect myself. Then, of course, we addressed the practical matter of whether it is appropriate to take a walk with a patient under these circumstances in the first place. The overall message of the supervision seemed to be that I should proceed with caution, as a psychotic murderer was potentially falling in love with me.

I thought the thread of this advice missed the mark. Of course, I did not want to be naïve to tricky transference issues, but I also did not want to get fixated on my own safety and lose focus on how it was that J.M., a person who was, by all accounts, profoundly impaired, could say those words in the first place. "I wish you didn't have to go. I wish you could stay here always, and we could take walks outside together." For me, that kind of revelation seemed almost unthinkable. Nobody in my day-to-day life talked like that, as all of our education and socialization had led us to shy away from such spontaneous expressions of emotion. Furthermore, my psychodynamic training had taught me more about interpreting subtle signs of emotional connection, such as a casual, "You look nice today," or "Thanks for returning my call so quickly," than it had about handling such direct expressions of desire. I tried my best to tolerate the discomfort I felt both about the incident itself and the advice I got from supervisors, but I could not sit still for long.

I quickly began to do what all good scientists are trained to do: generate hypotheses about J.M.'s behavior. Was it precisely because he lacked the usual social skills that he was able to express something so personal? Perhaps 20 years of psychosis and institutionalization had made his boundaries more permeable than my own? Maybe he was so internally preoccupied that he simply failed to notice that others didn't communicate their emotional needs with the same forthrightness? The more I thought about the incident, the more ideas I accumulated about areas to explore with J.M. I even dusted off my old psychotherapy textbooks to see whether a quick review of object relations theory or self-psychology could shed any light on the matter. I spent hours trying to combine J.M.'s psychosocial history, the neurobiology of schizophrenia, and various psychoanalytic theories into an elegant formulation that would help explain his recent behavior. Although my ideas fell far short of elegant, the exercise did serve to rejuvenate my enthusiasm for my work with J.M. after a long, dry winter.

I approached J.M. cautiously the following week, though he did not seem to notice. I hesitantly brought up what he had said about wanting to take a walk with me, and he responded by engaging in a very concrete discussion about whether the weather and hospital staff would permit such a thing. I made a valiant effort to get at the emotion behind the statement, but he simply would not budge. The moment was lost, and along with it went my excitement about our therapeutic renaissance. We were back to square one.

As I drove away from the hospital that day, my initial reaction to what had occurred (or rather, not occurred) was focused on myself and my own need to move forward with the therapy. Despite knowing that this kind of start-and-stop progress is common in therapy, it was hard for me not to be angry and disappointed that I didn't make more of the opportunity. I felt as if J.M. had given me a rare peek into his typically well-hidden emotional life, but then the door had slammed shut just as quickly as it had opened. Didn't he know that I had big plans for the therapy and important theories to test out? How dare he tease me with these juicy little morsels and then snatch them away! First, he had taunted me with his questions about desperation, and now he was doing it again with this "let's take a walk" business. I simply would not stand for it!

My anger lasted only as long as it took me to discuss the case in supervision again. My supervisor, who had actually treated J.M. on the inpatient unit 10 years earlier, told me that he was amazed J.M. had come even this far, as he was considered to be a hopeless case for a long time. He praised me for making a connection with J.M. and allowing him to feel comfortable enough to express such emotion in my presence. He also reminded me that many mental health professionals far more experienced than I had been working with J.M. for over 20 years, and I should not be displeased with making incremental gains within such a short time. He did not see the therapy as a failure at all.

After talking things over in supervision, my attitude about the "failure" began to soften as well. Somewhere along the way, I had forgotten what J.M.

told me at the outset of our treatment: that he was lonely and wanted to find a way to get close to people. In my effort to explain his behavior and tie everything together neatly, I didn't see that the request itself was a tangible step in the direction of closeness and intimacy. I also didn't see that, by asking me to take a walk with him, J.M. was giving me important information about his priorities for our time together. He was not asking me to "figure him out" or prepare a grand rounds-style case presentation that would explain why he committed his crime and how he could move forward with his life; he was asking me simply to have a human interaction with him. He was asking this not because he was incapable of being intellectually curious about himself, but because he instinctively knew that an emotional connection with me was more important. As I reflected on it further, I knew he was right. Who could argue that a warm hand to hold while strolling around the hospital grounds on a sunny spring day would do more to alleviate his feelings of desperation than a psychodynamic formulation would, no matter how elegant?

J.M. and I never did take a walk together. In fact, neither of us ever mentioned the idea again. As we progressed through the final few weeks of my fellowship, we followed the *Psychotherapy Termination Handbook* with precision, and the therapy ended with relatively little fanfare at the beginning of the summer. As far as I know, J.M. does not speak of me longingly or wax nostalgic about our year of psychotherapy. He fills his days with group therapy and a part-time job on the hospital campus, just as he did before we met. When I recently ran into someone who is still involved with his treatment, she told me that it remains to be seen whether he will be transitioned from the hospital to the community as planned. Discharges from the hospital are rare for insanity acquittees, as they require the agreement of multiple clinical and governmental oversight agencies, and everyone still questions J.M.'s ability to thrive outside of a highly structured setting. He remains an inpatient while this question is being resolved.

As for me, I have had some time to reflect on things, and I am plagued by one last question about J.M.'s request to take a walk with me. Why did he ask to take a walk in particular? Why not ask to see a movie or have lunch together? Although I am typically hesitant to read too much into isolated comments for fear of being too "shrinky," I have made an exception in this case. I like to think that J.M. was not literally asking me to take a walk with him, but rather to take a journey that began where I (like everyone else in his life) saw him simply as "murderer" and ended where we were just two people trying to get to know each other. Perhaps he was suggesting that this could best be accomplished outdoors, where the walls of the hospital would not encumber us, and we would be free to take whichever path we chose. I hope he would agree with me that we did take that journey, even if we never took the walk.

I also still occasionally come back to the question that so jolted me months before: "Do you know what it's like to be filled with desperation?" After a year together, I finally decided that I really don't know the same kind of desperation that J.M. does. However, when I think about his request to take a walk together, I am reminded that we are ultimately more alike than different. Although I may not know what it's like to be filled with J.M.'s desperation, I certainly know what it's like to be filled with the kind of longing for a human connection and the momentary dissolution of boundaries that led to his request. Moreover, I envied his ability to communicate that desire so openly. Of all the things I could have felt in response to J.M.'s request—fear, disgust, reciprocal longing—there is only one that has stuck with me over time. I have a fantasy that J.M. will ask me someday, "Doctor, do you know what it's like to be filled with admiration?" And I will reply, ever so simply, "Yes, I do."