The Uses of Benevolent Clinical Despotism

How can we manage our anxiety when helping patients requires taking a risk on their reliability? My new patient Donna was a case in point. A heroin addict recently released from jail and now in recovery on methadone, the mother of five children who were cared for by others, she had been regularly abused in childhood as well as by prior boyfriends. Whether or not one thought she had an anxiety disorder, she was, by her own admission, a nervous wreck much of the time. Many prior doctors had tried her—without success, she insisted, and I later confirmed—on the usual gamut of non-benzodiazepine antianxiety medications, understandably reluctant to give an addict something new to get addicted to. Now Donna was ruefully telling me that only the occasional pilfered clonazepam helped her to calm down and keep from relapsing. She was asking—not demanding—that I actually prescribe it for her. Was I crazy to even consider doing so?

Reflecting internally on this in the moment, the traditional “best practice” part of me remarked: “You are indeed crazy; how can you even think about giving an addict a medication she’s liable to use irresponsibly?” But the more flexible, patient-centered, and possibly gullible part of me countered with: “Look, she may not be reliable all the time, but some addicts only abuse their drug of choice. If she’s right about what helps, and can stay off heroin, off the streets, and out of prison at the cost of a few clonazepam tablets a month, isn’t that a victory for her?” Thus torn about how best to help her, I realized I could metabolize my own anxiety by being both patient-centered and doctor-centered: I could be a benevolent clinical despot.

What does this mean in practice? The benevolently despotic clinician feels comfortable dictating the rules of treatment but not guilty or judgmental when they are broken. She knows that patients often have concealed strengths under their obvious vulnerabilities. She is willing to take carefully calculated clinical risks when the potential benefits exceed them. She knows that such risks can be acceptable to the doctor and safe for the patient only if the conditions for treatment are clear and are enforceable—but are also agreed upon collaboratively. Benevolent clinical despotism can help doctors remain authoritative without becoming becoming authoritarian.

I told Donna that many doctors wouldn’t even consider her request, given her history of addiction—of course she already knew this—but that I was willing to take a chance on her provided she could adhere to very clear ground rules: regular visits, no early refills, no dose increases, no lost or stolen prescriptions. Any deviation from these rules could result in my stopping the medication—not as punishment, not because she had failed, but simply for breaking our agreement. I played the kindly tyrant, informing her that the new sheriff in town would do things his way, but fairly. I tried to appeal to the well-hidden mature functioning she retained—which I think she realized and appreciated. I established an oral contract with her, analogous to a written narcotics agreement. By keeping it oral rather than written, I hoped to emphasize a personal basis for trust rather than a legalistic one.

Donna immediately leapt at this idea, so I naturally wondered for a while if I was being played for a sucker. But the experiment appeared successful in that she used the medication according to our plan for well over a year, until the latest in her endless string of crises led to her increasing the dose on her own and running out of it early. When she begged me to take pity on her and authorize an early refill, the dose on her own and running out of it early. When she begged me to take pity on her and authorize an early refill, I had to don the benevolent despot persona and tell her something like: “I’m so sorry to hear that your son was arrested again … I know you’ll think I’m being mean and rigid—maybe even a pain in the neck—but we should stick to our agreement.” This meant giving her hydroxyzine or quetiapine until she was eligible for the refill, as well as a few days of diazepam so she didn’t go into benzodiazepine withdrawal. After a few more days of paging, begging, and grumbling, she stopped struggling and made it to when the next refill was due. Was she just buying pills on the street instead? Possibly—I couldn’t know. Given that she had gone more than a year without known troubles from the medication, I authorized the refill and we settled down for another two years of mostly regular visits and no frantic calls. She stayed out of jail and the drug screens performed by her methadone clinic were all negative.

Benevolent clinical despotism is the treatment of choice for any such situation calling for nonpunitive limit-setting. Managing anxiety with benzodiazepines is one familiar
example; another is the management of patients taking opiates. The anxiety that narcotic-dependent patients create in their treaters can be mitigated by this approach, which diminishes clinician helplessness and helps clarify and prioritize treatment goals, particularly in patients hospitalized for problems unrelated to narcotic use. The tendency for patients with severe character disorders to antagonize their treaters by inducing helplessness and even hatred can be effectively reduced by a benevolently despotic stance, which helps restore the treater’s sense of being in control.

After two more years, Donna paged me to say that her prescription was stolen from her gym locker the day she had it filled … and could she please fax me the police report of the theft so I could call in another month of clonazepam? She sounded desperate, and because I had gotten to know her, my instinct told me she was telling the truth. I still said no—benevolently. Once more we went through the same stopgap drill with different medications as described above, begging and grumbling included. If we can manage to do it only once every couple of years, I think we’ll both be satisfied—if not, I’ll pull the plug on our plan and we can at least say we tried. After all, the despot’s privilege is to say no at any time. The benevolent despot does so with regret.

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