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Current Psychology
A Journal for Diverse Perspectives on Diverse Psychological Issues

ISSN 1046-1310

Curr Psychol
DOI 10.1007/s12144-020-01055-x

Springer

Current Psychology
https://doi.org/10.1007/s12144-020-01055-x

The impact of a discarded diagnosis and focus on early warning signs of aggression on relations between user and municipal service providers - a narrative of a complex case

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Accepted: 9 September 2020

Abstract
By means of a nurse-driven risk management strategy, a community mental health nursing team was assisted in their struggles to cope in the care of a very aggressive and disturbed patient. The aim of this study was to discuss how a wrong diagnosis lead to relational consequences in care and how applying the Early Recognition Method (ERM) contributed to a relational change. Self psychology concepts were used to analyze and understand the underlying psychological process in the interaction between the nurses and patient. This case narrative illustrates qualitative research strategies through the lens of the theoretical framework of symbolic interactionism. Nurses gained a better understanding of the complexity of the patient and the nature and effects of their interactions with her. The patient's diagnosis was adjusted, resulting in perspectives that allowed for meaningful interactions and stabilization of aggressive behaviors. The most prominent result was the nurses becoming more confident and competent in their management of the care process. Nurses in community mental health care benefit from structured risk management strategies in unraveling the complexity of severe aggression. Self psychology is a meaningful lens by which to better understand the underlying psychological process in the interaction between nurses and a complex patient.

Key words Early recognition method · Self psychology · Risk management · Municipality mental health care

Introduction

Nurses working in community mental health care face a multitude of challenges because their roles, functions, and work conditions vary due to ever-changing day-to-day demands. Compared to nurses in traditional institution-based clinical work, these nurses play a somewhat generalist role with smaller and more heterogeneous groups of patients. Typically, in community mental health, broader health care challenges are often combined with severe and complex physical and mental health problems among clients/users. In addition, rural and remote contexts require the average community staff member to be a multi-specialist in a work environment that, most often, is not equipped to provide adequate care (Terry et al. 2015). An inquiry by Terry et al. (2015) into community workers' experiences resulted in the theme "working in isolation". They furthermore noted that the client's home was frequently experienced as a unique and "uncontrolled" work environment: Unanticipated situations could occur suddenly, with a high impact on daily work, and there were concerns for personal safety and limited management support.

Due to the solitary nature of this work context, there is also an increased likelihood for burn-out and work-related stress (Hanson et al. 2015; Lin et al. 2015; Terry et al. 2015). Koekkoek et al. (2011) investigated how 776 community mental health workers experienced so-called difficult patients, i.e. patients who often showed aggression and resistance to care. The health workers' most prominent response to these patients was "feeling powerless." This response reveals how these very complex treatment and care situations are highly likely to induce negative perceptions of patients' problems.

Aggression in the daily care process threatens the safety of nurses and, thereby, the continuity of care (Gudde et al. 2015;

Mesh Terms: Community mental health services, aggression, mentally disabled, risk management, Prader-Willi syndrome

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Published online: 16 September 2020

van Leeuwen and Harte 2017). Terry et al. (2015) found that 86% of nurses in remote areas of Australia reported experiencing violence or aggression, compared to 43% of nurses in urban areas. Workplace violence towards community workers has been shown to negatively affect job performance in terms of job dedication and task performance. In addition, work-related violence affects the quality of life and increases stress, depression, and sleep problems (Hanson et al. 2015; Lin et al. 2015). Swain and Gale (2014) illustrated how a communication skills intervention among community health care workers resulted in a reduction in the perception of aggression. Also, a systematic review of service users' experiences and views on aggression showed the importance of nursing staffs' knowledge and skills in communication in developing relationships based on sensitivity, respect, and collaboration (Gudde et al. 2015). Endeavors to manage patients' aggression often focus more on crisis intervention than on prevention. Whereas inpatient aggression in hospitals is broadly addressed in the research literature and in management programs, little is known about the management of aggression in the context of community-based mental health work.

This article describes a complex case of a very aggressive patient (Lotte) in a municipality mental health center. We had the following research questions: (1) How could the aggression of a complex case in a municipal mental health care be analyzed and understood? (2) What were the experiences of the mental health nurses with this case before and after the application of the Early Recognition Method? and (3) How could the development of the case be analyzed and explained embedded in Self psychology as the theoretical framework?

We will clarify how the Early Recognition Method (ERM) risk management strategy and Self psychology were applied in the analysis of the case. ERM is a risk management strategy that emphasizes the interaction between nursing staff and patients to identify and use early warning signs to develop risk management interventions (Fluttert et al. 2008; Fluttert et al. 2010). These so-called early warning signs can be defined as the subjective experiences, thoughts, and behaviors of a patient that occur prior to an actual aggressive behavior (Fluttert et al. 2011).

The aims of this article are the following:

1. To introduce Lotte, a violent woman with an erroneous diagnosis of Prader-Willi syndrome.
2. To discuss the relational consequences and strain the wrong diagnosis may have caused.
3. To show how implementation of the ERM contributed to relational change.
4. To use Self psychology to analyze the nurse-user relationship before and after the diagnosis had been reversed.

A Brief Introduction to Lotte and her Diagnosis

In the following observational case narrative, in which the ERM strategy was applied and studied, the complexity of community mental health care for a particularly aggressive patient, Lotte (not the actual name), will be outlined and analyzed.

We will explore the possible relational impact on service providers' understanding, care, and treatment after Lotte's diagnosis was changed. The diagnosis of Prader-Willi syndrome (PWS) profoundly shaped the dynamics between the patient and the nurses and limited the patient's social and emotional development (McCann 2016; Weiner 1986). One should bear in mind that PWS is a severe, and rare, condition caused by disturbed gene expression (Angulo et al. 2015; Sinnema et al. 2011a, 2011b; Ehrhart et al. 2019). The prevalence varies between 1/10,000 to 1/30,000, and it is a life-threatening condition due to the obesity that accompanies it. Infants with PWS have intellectual disabilities (IQ averaging 65) and behavioral problems such as temper tantrums, aggressive outbursts, and skin picking. Behavioral problems and compulsivity peaks during young adulthood, and a majority of individuals with PWS have been found to display psychotic symptoms (Sinnema et al. 2011b). Hence, the overall picture of individuals with PWS is that they are mentally disabled, have poor reality-testing abilities, are overweight, and struggle with a multitude of behavioral problems with aggressive episodes (Sinnema et al. 2011a). PWS is primarily diagnosed by a blood test.

A research approach was designed, and this case was approached and studied by means of the ERM risk management strategy (Fluttert et al. 2008). Through ERM observations, the case was re-assessed, and a new set of interventions was applied in order to contribute to a safer and more workable care process. The aims of the research were (1) to implement ERM to enhance staff's and Lotte's management of her aggression and to mitigate risk of further aggressive episodes, and (2) to scrutinize possible changes in staff's understanding, perception, and interaction with Lotte after ERM was applied.

Theoretical Framework

Self psychology was used to analyze the psychological processes underlying the interaction between the nurses and the service user and how the related responses of nursing staff may have affected her violent behavior. Self psychology was developed in the early 70s by Heinz Kohut (1971) to provide new insights and analyses about how relations with significant others (*self-objects*) may enhance or disrupt a person's development. Self-objects can be defined as transitional objects which meet needs for presence of an alter-ego or twinship, reflecting and paralleling the self, or the mirroring of

oneself in another, or an idealized figure that meets grandiose, exhibitionist needs feeling special, and protected (Angelina 2013). The function of good self-objects in milieu treatment is to enhance the service user's ability to maintain self-structure, a sense of self, self-cohesion, and self-esteem (Banai et al. 2005). Of central importance in this perspective is *empathy*, which is referred to as the skill to experience the outside world from the patient's perspective (Baker and Baker 1987; Rabstejnek 2015).

The main reason for choosing the Self psychology perspective for analyzing the interaction between Lotte and the nurses was that Self psychology analysis is a combination of a systemic (self-object relations) and a phenomenological approach (self-esteem and sense of self) (Amineh and Davatgari 2015) . Used together, this combination opens up the possibility for better understanding of Lotte, the service users, and their mutual interaction before and after the ERM intervention and the reversal of the Prader-Willi diagnosis. We focused on emphatic attunement and failure and self-object relationships in our analysis. Kohut (1984) understood empathic attunement as experience-near observation and responding. He claimed that the main goal for the Self psychology therapist was to create a new kind of experience for the patient by being a self-object. This was a giant step away from his psychoanalytical background, which emphasized interpretation as the significant agent of change. The positive value of self-objects is their internal functions for the patient and the emotional stability they bring. Self-object needs are influencing the developing self and are lifelong, and acute trauma or long-lasting failure to meet these needs disrupts self-cohesion, self-esteem, and sense of self. Without positive self-object experiences, internalization of a "healthy self" cannot occur, and shame, humiliation, and helplessness result. A person with compromised self-cohesion will lack internal control over her behavior. This will increase the risk of, for instance, violence against others, self-harm, drug abuse, and so forth. Successful therapy depends on establishing and sustaining good enough self-object relations. Kohut (1984) emphasized sufficient mirroring of the patient as a necessary building block in restoring a healthy self. The first self-object need and the main function of a mirroring self-object is to help the patient recognize and acknowledge her resources and capabilities (Kohut 1984).

Methods

Design and Participants

This is a naturalistic, observational case narrative (Baxter and Jack 2008) centered on the living and treatment context of a 39-year-old female patient named Lotte for purposes of anonymity. The staff involved in Lotte's care were 14 female and 2 male nurses with a mean age of 40.4 years (range 33.9–46.8). Their experience as nurses varied from 2 to 16 years (mean = 8 years).

Procedure and Materials

Data for this case narrative was obtained through three strategies: (1) data collection of written materials concerning the patient's history and characteristics, (2) qualitative interviews of staff, and (3) risk management data analyses of ERM early warning signs of aggression. In more detail, the following procedure was undertaken:

(1) In order to increase reliability of this case narrative, a case data protocol and case database were established (Yin 2009). In the protocol, the study interventions included clinical data and group interviews of staff. Data of patient's history and clinical data concerning life history, life events, and the patient's characteristics were collected from multiple sources, such as medical records, nursing reports, historical descriptions, private notes of the patient's mother, and ERM risk management recordings. A triangulation of data from many sources was performed in order to have more reliable and valid data (Yin 2009).

(2) The nursing staff team was interviewed in April 2015, October 2015, November 2015 and August 2016. The inclusion criteria for staff were, respectively, to be involved in the care for the patient and that they attended the ERM-training. The interviews were scheduled during the shift handover meetings, hereby securing that all attending nurses participated in the interviews. At each interview between 5 and 8 staff members participated. The first and third authors conducted all the interviews. Three of these interviews were recorded by means of taking notes; the last conclusive interview was audiotaped and transcribed.

Interview data were analyzed in four steps, according to the theoretical framework of symbolic interactionism (Miles et al. 2014). First, texts were explored line by line and labeled with code words. Second, all texts were read again and mirrored against the code words. This led to more abstract categories and sub-themes covering staff experiences with the case and with ERM. Third, the total text was examined again in a discussion between authors as to whether the themes captured all the data. Fourth, we discussed how the themes could be understood and where to merge them, which led to an initial concept. This concept could explain how the case could be understood from the perspective of the diagnosis, aggressive behaviors, and early warning signs, and, moreover, how the staff experienced this new perspective. In the final stage of the analyses, and in order to check whether the

data were understood correctly, initial findings were discussed with the staff. Staff were here also asked about the current situation and if new experiences (data) could be added in order to shed light on the developments with Lotte.

(3) Finally, risk management data were sampled and studied by means of applying ERM. The focus was on the identification and management of early warning signs of aggression. The Forensic Early Signs of Aggression Inventory (FESAI) is a tool designed to assist nurses in identifying a patient's subjective early warning signs (Fluttert et al. 2011). Staff members monitored and evaluated the patient's behavior systematically in order to recognize these warning signs at an early stage. In the ERM Plan (Fig. 1: ERM Plan), three levels of severity of the early warning signs are described, ranging from *stable*, to *moderate*, to *severely disturbed*. When early warning signs occur, preventive actions could be applied in order to stabilize the behavior. In this particular study, staff members recorded the patient's early warning signs of aggression on a daily basis. These data were plotted on a spreadsheet and prepared for further examination, such as, for example, the relationship between the different levels of severity attributed to the early warning signs when they were displayed. Every day at the treatment meeting, by use of the ERM spreadsheet, staff discussed their observations and recording of early warning signs and the patient's behavior. Staff also discussed how the patient's behavior was associated mutually with her emotions, such as anger and anxiety. The next topic was to discuss how the staff intervened in response to the early warning signs. An interesting focus in this analysis was how interventions could affect the patient's behavior and whether this had enhanced her emotional and behavioral stability. At these meetings the staff also discussed how to cope when their interventions didn't bring any improvement in her behaviors.

Case Presentation and Analyses

To present this case, we followed the recommended format in *Guidelines to the Writing of Case Studies* (Budgell 2008) and added a paragraph, "Case Analyses". The presentation begins with a description of the history, results of medical examinations, and other facts of the case. Specific literature concerning Prader-Willi syndrome was researched in order to gain a better understanding of the patient's symptoms. Next, under "Management and Outcome," the ERM method is explained and the case planning and care is unraveled and specific problems and challenges are identified. In "Case Analyses," the case is analyzed in depth by a time series analysis (Yin 2009) to describe "how" and "why" perceptions and to identify nurses' care patterns. Additionally, we analyzed how the patient's behaviors could be understood in view of theoretical propositions, thereby attempting to explain and find links between case-specific phenomena, such as life events in the patient's history and displayed aggression and disruptive behaviors.

Supervisor and Research Roles

* and *** were initially asked to assist the team as supervisors. However, as they gained more insight into the complexity of the case, they assessed it as being suitable for research, with a more systematic approach. The aim was to unravel the underlying processes at work between the patient and the staff. This decision implied that * and *** would not interact with the patient and would not interfere in the actual contact between staff and patient, apart from advising staff how to apply ERM and stayed in their role as researchers,

Ethics

The project was approved by the Regional Ethical Committee (REK). The patient's mother, acting on her daughter's behalf, gave written consent. Measures were taken to insure that the patient would not be recognizable. No coercion or harm, nor any other types of intrusive interventions, were applied to the client in relation to this study.

In addition, no participant observations were done. Neither did we supervise staff in terms of finding practical solutions in their day-to-day management of care, except for implementing the ERM approach. By keeping our distance from the patient and staying "hands off" in relation to ERM, our objective was to gain a more objective position as researcher and supervisor of the team.

Results

Case Presentation

Lotte (39) grew up in a town in Norway in a family with three elderly brothers and well-educated parents. All three brothers went to school and experienced normal school and job careers. Lotte did not like her youngest brother, who she remembered as rude. At the age of three, Lotte lost her father to brain cancer, which has been described as a terrible blow, both to her and the rest of the family. A few years later, Lotte's mother was admitted to hospital where she spent a long time for cancer treatment. During that time, Lotte stayed in several places with relatives and acquaintances of the family. Lotte has told staff that she remembered her youth as being very unpleasant.

Early Recognition Method (ERM)

Early Detection Plan

Client: _____

Contact-person_____

Date _____

EARLY WARNING SIGN 1: Gloomy / despondent aggressive facial expression				**Context** During staff contact in her apartment.										
Date	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Level 3: Severe Throwing objects			X				X				X			
Level 2: Moderate Some unrest; repeating questioning similar issues; seems irritated.	X	X		X				X	X	X		X	X	X
Level 1: Stabil In good spirit and interacts nicely with staff					X	X								

EARLY WARNING SIGN 2: Continuously walking in and out the apartment				**Context:** At daytime when the apartment is unlocked.										
Date	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Level 3: Severe Restless movements in and out the apartment accompanied with shouting loudly.	X		X					X			X			
Level 2: Moderate Going more into the veranda with irritated expression		X		X			X		X	X		X	X	X
Level 1: Stabil Stays most of the time inside waiting for the regular visit moments of the staff					X	X								

Fig. 1 Excerpt from the ERM-Plan

At the age of seven, Lotte went to primary school. Reportedly, she had no friends, was bullied, and showed idiosyncratic behaviors, such as licking windows, and dissocial behaviors, such as randomly attacking others. In the absence of any other measures, she was often taken out of school and sent home alone without any supervision. Due to her instability and increasingly aggressive behaviors towards others, Lotte's mother decided to send her, then 13, to a special school for children with conduct disorders. During this period, from age 13 until 18, Lotte constantly showed behavioral problems and aggression towards others, including attacks of rage. Lotte remembered that she had to stay at home alone each day after returning from the special school, while her mother worked.

At the age of 20, Lotte started work at a rehabilitation workplace for clients with intellectual disabilities. In order to be admitted to this facility, she needed to be diagnosed accordingly, and, henceforth, she was categorized as being heavily cognitively impaired. This was also her first contact with the mental health system in the form of the specialized habilitation team at the local hospital who have followed her ever since. In spite of her aggressive episodes, she managed to maintain, and do, simple work under personalized support and supervision. After two years working at the rehab-workplace, and due to the continuation of her behavioral problems and aggressive episodes, she was admitted to the community-based mental health service.

When Lotte was 30 years old, she moved to the current sheltered home apartment in a rural area in Norway with 24/7 nursing service. She was diagnosed with Prader-Willi Syndrome [PWS]. Her mother never agreed with this. The PWS was not determined by a blood test, but primarily based on observational data – her aggressive behavior, her obesity, and eating problems – which were combined with the initial diagnosis of mentally retardation (one of the key symptoms of PWS). Her IQ was estimated to be below 70. Within the mental health municipality services, she was referred to as *the Prader-Willi case* with specific reference to her having behavioral problems such as "'picking", which is perceived as an attempt

on the part of a client to injure others by sticking a finger in someone's eye, nose, or other body parts. The nurses working with Lotte experienced her as a *very complex case* due to the mix of demanding needs in daily care and very high rates of aggressive acts, manipulative, and hard to manage. This was all explained by the presumed diagnosis of Prader-Willi syndrome (Angulo et al. 2015; Sinnema et al. 2011a, 2011b). This diagnosis was later proven wrong and tragically misleading for nurses, family and other persons surrounding her.

It was also taken into account that Lotte was hugely overweight and seemed to lack the capacity to take care of herself. Hence, 24/7 support from the mental health municipality nursing staff was indicated. The aggression Lotte showed dominated her contact with the nurses and was usually displayed suddenly, without a noticeable trigger. In addition to Lotte's behavioral problems, staff felt manipulated by her. In these circumstances, she was perceived as displaying some sort of "Dr. Jekyll and Mr. Hyde" personality, that is, she seemed to switch between being compliant and remorseful to suddenly attacking staff with impunity. This implied that she had two alternating modus operandi: one characterized by physical aggression (e.g., by beating or scratching) and the other, by calmness and responsiveness, even having the ability to reflect upon her own aggressiveness and lack of control.

The work environment was also burdened by the lack of an overarching risk-management strategy. Hence, the nurses worked with Lotte in what might be described as a day-to-day "survival mode". Ultimately, this highly demanding case led the nursing team to seek assistance in the management of Lotte's aggression in order to avoid staff burnout. At that point, the authors * and *** were brought in to assist the nursing team in the management of Lotte's aggressive behavior.

Management and Outcome

ERM Intervention

The systematic ERM risk management intervention aimed at unravelling Lotte's behaviors and assisting the staff in terms of ERM. For four months, the staff were trained in how to apply the ERM protocol, after which they were monitored for 12 months while they followed Lotte's ERM protocol and ERM Plan, which was slightly adjusted and tailored for this specific case. * and *** visited the nursing team every three months to discuss the progress of the ERM application and developments with Lotte in relation to this. This happened after Lotte had been 16 years in care at the municipality centre.

The outcome of applying ERM are early interventions triggered by person-specific early warning signs. An example of this was that the staff noticed the start of her being annoyed by changes in her facial expression. By disclosing this observation to Lotte, she could experience that she was not isolated in her mood changes. Nurses learned both to understand and manage the upcoming stress in Lotte.

The municipality health team administered care to Lotte on a 24/7 basis: per week, 16 nurses were involved. From morning until evening, at least two nurses were present in Lotte's apartment. The nurses focused on regulating Lotte's hygiene, eating, leisure activities, and, foremost, on monitoring her aggressive and disruptive behaviors – privately, during transport, and in public. All care activities were initiated by the nurses due to Lotte's perceived and diagnosed low cognitive capacity. Consequently, she was allowed hardly any autonomy and was never stimulated to exercise or develop any type of self-sufficiency.

Although Lotte was formally considered heavily mentally impaired, nurses did not hesitate to regard her as having more developed mental capacities than her diagnosis would indicate. Quite often they observed that she could, seemingly deliberately, manipulate them in their daily contact by, for example, choosing to obey one nurse and obstruct another. At such moments, Lotte's cognitive capacity seemed to be significantly higher than what would be expected in a person with intellectual disability.

The pivotal issue in the care process was the occurrence of Lotte's aggressive episodes. Mostly without a noticeable trigger, Lotte could begin kicking, skin-picking, and showing rage. This put enormous pressure on the staff who always felt they needed to be alert for possible aggression. The communication with Lotte was narrowed down to brief questions and answers, since conversations or just chatting were not feasible. During aggressive episodes, staff primarily coerced Lotte by holding her, sometimes for hours. This holding procedure burdened the staff mentally and physically to such a degree that a physiotherapist was even drawn in to assist staff and teach them how they could avoid pain during and after the holding episodes. Naturally, these episodes were severe to cope with for Lotte, too, since she very often encountered and experienced hostile interactions with staff. These aggressive episodes occurred almost daily and were administered as routine care for six years.

In 2013, the nursing staff articulated to * and *** their desperate need for any type of risk management strategy in order to contain and regulate Lotte's aggression and alleviate them from burn-out. The staff also questioned the diagnosis of PWS and Lotte's presumed intellectual disability. It occurred too often, they reasoned, that Lotte made manipulating remarks, such as "I will start or keep on hitting!", just before and during aggressive episodes.

Case Analysis

Lotte grew up in a family that lacked stability and care. She lost her father at age four. Further on in her early youth, Lotte

experienced severe loneliness, both when her mother was absent due to sickness and when she was left at home, without any care, when her mother was working. Furthermore, she frequently experienced aggression from others, like, for example, being bullied and alienated in primary school. To counter these intrusions, and perhaps to keep other people at a distance, she increasingly displayed aggressive behaviors.

Evidently, she did not get the chance to experience and develop normal social interactions, neither at an early stage of her life or later on, due to being misconstrued. For instance, when treated as incompetent and retarded, Lotte responded with aggressive and erratic behaviors. These were systematically interpreted as signs of her having PWS, a condition towards which no measures other than the most primitive, such as coercion, holding, and locking in, were regarded as suitable. Ultimately, the diagnosis of PWS and the lack of meaningful relationships kept Lotte from developing any kind of social autonomy or basic self-preservation skills; she became increasingly adept at manipulating and controlling staff.

In self-psychological terms, Lotte's aggressive behaviors might be understood as expressions of the type of narcissism that evolves due to a lack of stability and support during childhood. The basic assumption in Self psychology is that, under normal circumstances, a child will develop a healthy sense of her*self* and maintain consistent patterns of behaviors, experiences, and self-regulation. Parents are the most important so-called self-objects of a child, from which he or she can experience positive transference in the sense of being adequately and sufficiently mirrored. Also, children relate to their parents as those they can idealize or feel a sense of likeness with. In Lotte's case, however, the parent system failed because of parental death and illness, resulting in a lack of empathic and supportive responses when Lotte was at a critical developmental stage. Consequently, Lotte's self-development was disrupted, and she did not reach age-adequate levels of maturity regarding self-esteem and self-regulation.

According to her mother and brothers, the death of Lotte's father probably traumatized her in that it represented a loss of a person who could have provided "transference of calm and comfort." What followed was the diametric opposite – a life of fear, alienation, and emotional under-stimulation, where Lotte was frequently left alone at home and encountered aggressiveness from others, both domestically and at school. Left with few other alternatives, she most likely used her rage and dissocial behaviors to shield herself from the ugliness and emptiness of the outside world. In conjunction to her aggressiveness Lotte learned how she could get attention and shape her environment through random and awkward behaviors, e.g. by licking windows. Hereby, she seemed to have developed manipulative "skills", reflecting her narcissistic personality, in order to get more control.

When the Prader-Willi diagnosis was established, her highly fragmented, narcissistic personality was, even more than before, negatively reinforced through nurses' reactions to her awkward and aggressive behaviors. Lotte was now, de facto, treated as a person with severe intellectual disability, and the interaction between her and her nurses was mostly triggered and driven by responses to aggression. Furthermore, and most importantly, the staff did not focus on establishing empathic attunement in the relationship, as this is defined in Self psychology: an essential understanding and experience, from the patient's perspective, of how she perceives herself and others, especially her self-objects, such as parents and nurses. In a healthy social system, the client can have positive experiences when interacting with self-objects because these are adequately attuned to her emotional state and cognitive level. However, in this case, staff were wrongly attuned to Lotte because they attributed her manipulative aggressive behaviors and disturbed eating patterns to the PWS and impaired cognitive functioning. Lotte, being consistently misread by her nurses, was, for her part, free to manipulate them by systematically feeding into their misrepresentations of her with ever more intricate and erratic behaviors. By these means, she reinforced the staff's image of her as being irredeemable, and, at the same time, her narcissistic needs were gratified by getting her maximum attention from her nurses. After a while, some of the staff members broke out of this vicious circle by, seemingly, establishing more insight into her behaviors and motivations, that is, they became more empathetic of her. This also led to the depiction of her as being a so-called Dr. Jekyll and Mr. Hyde; there was obviously more to her than met the eye.

When Lotte was admitted to mental health care and was treated as a Prader-Willi case, she lived a highly secluded life, cut off from the outside world and with only sporadic contact with her mother and siblings. This exhausting care process lasted for years in which nurses, on a daily basis, faced stress, aggression, and, simultaneously, tried not to break down or burn out. At that time, it was proposed to start a pilot study, applying ERM in an attempt to gain a better understanding of the early warning signs in Lotte and, accordingly, to plan possible early interventions.

The following early warning signs and contexts were identified, described, and recorded: *(1) gloomy, despondent aggressive facial expression [context: when she wants clarifications or has questions], (2) repellent and gives little eye contact [context: during stay at the apartment], (3) looks tired and drawn in the face [context: at the first contact in the morning], (4) not very talkative [context: during a car drive].* Apparently, when nurses observed, for example, her facial expressions and eye-contact, they could identify possible precursors of aggression. Each of these four early warning signs was described in further detail and on three levels, from *stable* to *deteriorated*, in the ERM plan. It was recorded daily at which of the three levels an early warning sign was observed.

Using ERM, nurses became more confident in observing early warning signs and managing Lotte's behaviors. For the

first time, early interventions were applied, such as mentioning to Lotte what the nurses observed and making Lotte responsible for gaining control of her behaviors. As the months passed, Lotte's mental condition seemed to improve. The frequency and severity of incidents decreased, and nurses perceived Lotte as showing increasingly more capacity to interact with them.

Due to this positive development, nurses started to seriously question the diagnosis of PWS. The most important reason for this was her ability to respond adequately when she was reminded by nurses of her early warning signs of aggressive behaviors, that is, understand the seriousness of the sign and then mobilizing self-regulation. Also, Lotte took notice when nurses explained to her that the long "holding moments" could be avoided if she managed to take more responsibility instead of just randomly causing damage. Finally, when staff took into account the characteristics of PWS (as outlined by Sinnema et al. 2011b), such as psychosis, mentally retardation, and becoming less aggressive in adulthood, Lotte's symptoms and behaviors did not really fit to the diagnosis. It was then decided to administer a blood test to clarify, once and for all, whether the PWS diagnosis was correct. Prader-Willi was not detected in her blood sample. This, again, spurred a re-assessment of her cognitive level, resulting in a new diagnosis of "moderate developmental impairment, implying an IQ level significantly above what was earlier suggested."

The four interviews with the staff team resulted in the following themes: (1) risk management by means of recording early warning signs, (2) aggression management by a limit-setting, "hands off" approach and applying early interventions, (3) involvement of Lotte in shared decision making concerning her daily routine, and (4) the involvement of Lotte's mother in activities.

Lotte showed more initiative interacting with staff when she said, for instance: "I also want to discuss with you [i.e., staff] things which I find important such as how to spend my pocket money." She became more connected to the outside world, asking, for example, for more walks outside her apartment. Lotte also commented on her experience in relation to staff: "I enjoy it when you compliment me and give me an extra reward!" Once when she showed anger and started crying, staff asked her what was happening. Lotte explained: "I am angry because I have a headache and my family is having problems that makes me cry." By telling the staff what bothered her, she could calm down. Such self-reflections and interactions with staff had not occurred before.

In sum, the ERM approach provided a framework within which nurses started to feel more confident and competent in coping with Lotte's behaviors. Because of the systematic use of early warning signs and engaging Lotte in the process, Lotte gradually showed more stable behaviors. The number of aggressive incidents decreased, from almost daily outbursts of aggression to only occasional and milder displays of early warning signs of aggression, which very seldom developed into actual incidents. As well, the method of holding Lotte when she was aggressive was terminated. Increasingly, the nurses could allow Lotte to have her bad moods, and, at those times, guide her to calm down and encourage her to focus on doing, for example, leisure activities. Nurses also managed to motivate Lotte to engage more with the outside would, such as to go out of the apartment and meet others, her family, and especially have quality time with her mother, though there still existed some tensions in this relationship. For the first time, she attended a church meeting without losing her calm and even started singing in a choir.

What had seemed impossible two years earlier was now happening: Lotte was having brief, but meaningful, interactions with the staff. Hence, the staff experienced themselves as being in an assisting and empowering role. The staff now represented a stable factor when problems arose, by, for example, setting limits to aggressive behaviors. At the same time, they expected Lotte to take responsibility for her actions and exert age-adequate, self-regulatory capacities.

By means of the ERM framework, Lotte has exceeded far beyond her prior state of seclusion and chaotic interactions. While in the "old days", she was constantly restless and showed erratic behaviors like licking the products in shops, she now manages to go out shopping with staff in a good atmosphere without any kinds of disruptions. Moreover, she has also asked staff what she could do to earn more pocket money. When shopping with nursing staff, Lotte appears calmer, lets herself be guided by the staff and, in contrast to her behavior before ERM, avoids shouting or exerting restless behaviors such as running off. Also on a positive note: When Lotte's brother visited her, for the first time in many years, the visit unfolded in a calm atmosphere, without Lotte constantly touching him. Later, when the staff complimented her for this, she was very content. This is an example of the staff taking a mirroring self-object relationship toward Lotte. Conversely, the staff reported no examples of being in a twin-ship self-object relation with Lotte, which is more likely to happen if Lotte keeps on developing her social skills and interest for a "normal" life.

In view of her improvements, steps are presently being taken to reduce the number of staff involved in Lotte's weekly care from 16 to 9. In addition, moving her to a new flat without a permanent personnel base attached to it is under consideration.

Discussion

Municipality mental health care services are predominantly organized to assist and manage patients in their daily care activities. Therefore, particularly complex cases that demand systematic assessment and accordingly planned guidelines for managing, for example, aggression, are most often beyond the

staff's reach in terms of clinical and case management competence. This case narrative illustrates how such a competence gap can be filled. It also underlines the necessity of a precise assessment and diagnosis of patients' capacities concerning their abilities to both understand and control disruptive behaviors. Moreover, an accurate picture of a patient's capacities and vulnerabilities using measures such as the ERM can, potentially, guide staff to develop and apply tailor-made risk management strategies and be instrumental in the development of more fruitful interactions between staff and patients. The case presented here is a good example of how an idealizing self-object role can be developed through structured clinical work, such as the ERM, especially when a case involves violence, which is at the extreme end of behaviors and burdens staff have to cope with.

The main aims of this article were to introduce Lotte, a violent woman with an erroneous diagnosis of Prader-Willi syndrome, and to discuss the relational consequences and strains the wrong diagnosis may have caused. We aimed to show how implementation of the ERM contributed to relational change and how Self psychology was used to analyze the nurse-user relationship before and after the diagnosis had been reversed.

Lotte had a volatile youth. It appears that with her father's death and the absence of her mother, the structure and balance of her family was broken. The loss of her father can be interpreted as an early childhood trauma. It seems that her youth was filled with a wide variety of negative experiences from which, one might imagine, a kind of "survival mode" was developed. Her autonomy was never developed during childhood and adolescence. Moreover, the early diagnosis of PWS seemingly dismissed her from being responsible for her behaviors, which again blocked the development of deep and meaningful attachment with others. Also in the later care process at the Municipality mental health service hardly any type of normal relationships or interaction patterns between Lotte and the nurses developed. Ultimately, Lotte became victim of a vicious circle.

ERM was introduced to the staff in order to gain better insight into Lotte's aggression and how to manage this, but soon this framework became a "game changer" in that the focus was no longer on the crises and awkward behaviors but rather on being aware of and responding to the early warning signs. Within this new paradigm, Lotte moved from being highly unstable and unpredictable to being stable, self-aware, and able to reflect on and take responsibility for her own actions. Equally instrumental in this change was the withdrawal of the PWS diagnosis. Hence, the staff's experiences with Lotte after ERM was introduced can be divided into two phases: The first phase, when the presumed initial diagnoses still guided them, they were more or less paralyzed in their day-to-day survive mode. In terms of Self psychology, the staff's mirroring self-object roles were unintentionally dominated by negative attunement to Lotte. This is a major threat to development of a balanced and trustful self. In the second phase, after the initial PWS diagnosis was withdrawn, and ERM was implemented in its full extent to monitor and mirror Lotte's behaviors, staff members gradually managed to develop a working relationship with Lotte, hereby also quell her manipulations and aggressiveness. Apparently, the staff now perceived themselves in an idealizing self-object relationship, signifying that they had moved away from a disruptive relationship caused by a failure of empathic attunement. Lotte had probably not felt that the nurses attuned to her self-object needs, and this failure blocked any development of a healthy self within her. Quite on the contrary; instead of learning to deal with frustration in an emphatic relationship, Lotte and the nurses had been trapped in interactions that only exasperated frustrations and conflict.

The early interactions between Lotte and staff seemed to be a profound factor. Her behaviors were then, by default, fully attributed to her diagnosis and presumed low intellectual capacity. In addition, as she was considered to have PWS, for which there is no cure, no considerations of future developments were exercised. Thus, since all observed behaviors were perceived within the framework of PWS, it appeared this diagnosis blocked the development and implementation of treatment and risk management strategies. Most probably because the staff thought that violence was included in the diagnosis, so there was nothing that could be done about it. And without a deeper understanding of the communication dynamics embedded in the violent episodes, the staff appeared to have gone into a "survival mode" which hampered them from being in a good self-object relationship with Lotte.

Lotte's disruptive behaviors were attributed to her presumed genetic disease. Interestingly Lee et al. (2014) studied the phenomenon of the relationship between attribution to a genetic disease and social distance and helping decisions. In their study, 149 students were randomly assigned to read vignettes depicting persons suffering from either genetic or environmental causes. The results suggested that attribution to genetic causes decreases the likelihood of helping people. This is mirrored in how nurses in this case explained how they, in practice, had given up on Lotte until the diagnosis of PWS was withdrawn.

The second phase of the ERM period, i.e. post-PWS, opened up a wide variety of new opportunities for staff to stabilize, interact, and communicate with Lotte. As in the Helen Keller case (Nielsen 2004), nurses and patient were able to, at last, understand each other in a reciprocal fashion. Helen Keller became deaf and blind due to illness at age one-and-half. In her young childhood, she could not communicate with the outside world. At the age of six, when she met a teacher, Anne Sullivan, for the first time, she aggressively kicked the teacher in the teeth. Nevertheless, the teacher became a great "self-object" for Helen. By being empathetic and adequately attuned, she induced stability in the relationship and managed to "mirror" Helen's experiences and emotions. Building upon this groundwork, she also managed to teach Helen to communicate by finger-hand touch, which totally redefined Helen in

terms of how she functioned in the world, her self-esteem, and her ability to communicate. Ultimately, she was saved from being a "lost case" and went on to become a Masters graduate and a renowned author and lecturer. She advocated the importance of intersubjective connections and interactions, hereby reflecting the self psychological terms of empathy and attunement, that is, of being truly understood and affirmed by a significant other (self-object).

Lotte's underlying narcissistic needs are now contained and responded to, primarily, by positive attention. Hence, her tendency to manipulate to gain attention has declined. This "new" kind of empathy for Lotte seems to have stabilized the interactions between Lotte and staff: by functioning as Lotte's self-objects and being more precisely attuned to her affective and cognitive mode, the staff have helped Lotte to become less fragmented and narcissistic. In other words, she seems to experience more fully the extent of her own "self". In addition, the staff use, for example, a step-by-step mirroring method to explain to Lotte how her aggression is not beneficial and will not be responded to any more. They have also moved from a hands-on to a hands-off approach in cases of aggression. All in all, these changes seem to have established and sustained a relationship based on care, support, calmness, and mutual respect.

Limitations

For ethical purposes we chose not to involve the patient directly in order to detect how she experienced her wellbeing and behaviors. Since we neither met her nor spoke with her, this evidently limits our possibilities in terms of valuing and interpreting, from her perspective, how the wrong diagnosis has impacted her.

The study is based on collected data, i.e. clinical reports and assessments, the nurses' reports and the nurses'oral communications. It must be taken into consideration that much of the information about Lotte, pertaining to both her history, development, relationships and past and present behaviors, could have been negatively biased towards her. Nevertheless, much effort has been devolved to creating as precise a representation of Lotte as possible when processing and interpreting the recorded data (written transcripts, tape recordings). Adding to the credibility of the results is the systematic approach involving a round a validation of initial findings together with the staff in the final tape-recorded interview.

This paper provides a divulging glance into the impacts of a false diagnosis on the care and wellbeing of a person with a complex condition. However, the key dynamics of this qualitative case narrative cannot, necessarily, be extrapolated or generalized to other cases since they are unique and must be understood in view of Lotte's particular condition and life circumstances.

ERM is a risk management strategy based on observations and interpretations. Despite the fact that the nurses were trained in applying ERM, this was the first time for them to be involved in a protocolized risk management strategy. This was thereby a challenge given the limited opportunities co-author * had to provide and repeat ERM-training sessions.

The window of observation and study of this complex case was 3 years. Within these years there were minor changes in the nursing team, which had to be anticipated by means of forwarding the ERM within the team and not always by an update training session. Nevertheless, the ERM protocol provided guidance for new nurses on how to understand and apply ERM.

Finally, a more frequent interview schedule could perhaps have resulted in even more accurate observations of Lotte's development and the nurses providing care and applying ERM. This would also have opened up for the data collection of interviews with tape recordings being the rule, not the exception.

Concluding Remarks

This case study has shown how ERM has provided the framework for a systematic and tailor-made risk management strategy in a context where competence and coping with inpatient aggression had to be improved. Furthermore, it has demonstrated how ERM has been instrumental in breaking a vicious circle fueled by narcissism and erroneous attribution. Most profoundly, the ERM framework has unlocked the barrier between a fragmented and traumatized person and her closest nurses.

All in all, the preliminary results are striking: the aggressive episodes have almost completely ended, Lotte has started participating in social events, and the staffing can be decreased from 16 to 9 nurses. Moreover, Lotte's mother can now be more involved in Lotte's life. Crucial to these developments, and to their sustainability, is the role and actions of the mental health care-givers, particularly their ability to engage with Lotte consistently and with empathic attunement. Lotte will be vulnerable to any deviance from the current quality of intersubjective connections between her and her nurses. In other words, insofar as future nurses are not able to meet her with empathy and to mirror her adequately, or lack routines with regard to managing aggressiveness, it could happen that all the progress obtained in the past two years could be rolled back within a very short period of time.

Although this study points to ERM as a highly potent catalyst in a complex and intractable case, one cannot, unequivocally, portray this particular method as a panacea for other, similar contexts. As shown, many factors must work together in order to succeed; a framework for understanding and predicting unwanted behaviors (ERM) must be combined with an emphatic approach to the patient, which again, must

correspond to, and reflect, a precise clinical understanding of the particular person. Our experience is that Self psychology provides a fundament for understanding relations and changing interactions for the best for service providers and users.

Compliance with Ethical Standards

Conflict of Interest On behalf of all authors I would declare that the manuscript or its content has not been published before and is not being considered for publication elsewhere. There is no other conflict of interests.

Ethical Approval Before starting the study described in the manuscript, ethical approval was obtained and admitted by the Regional Ethical Board of the region in which the study was done.

The name of the Regional Ethical Board is:

REK sør-øst, Regionale Komiteer for Medisinsk og Helsefaglig Forskningsetikk, 0484 Oslo, Norway.

Informed Consent All staff members involved in the study received before participating in the interviews informed consent and a full explanation of the aims and procedure of the study. This informed consent was done verbally and by means of an Informed Consent form which signed by all staff involved. .

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