



An empathic, relaxed approach can ease frustration and improve the therapeutic alliance

Transcend dread

8 WAYS TO TRANSFORM YOUR CARE OF 'DIFFICULT' PATIENTS

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In a psychiatric clinic, Dr. B treats Ms. D, a single 28-year-old, for depression. She has multiple pain and gastrointestinal complaints that have responded poorly to treatment, morbid obesity, chronic tiredness, irritability, and Cluster B personality traits. Ms. D is lonely, unemployed, and seems to be in perpetual crisis. She states “unless someone does something to make this better, I just might kill myself.” She blames Dr. B for failing to adequately treat her depression; he has tried many medications to no avail. In psychotherapy sessions, Ms. D complains instead of examining methods for improvement, and she does not complete psychotherapy homework. She is extremely passive in her approach to getting better.

Ms. D asks Dr. B fill out the necessary paperwork so she can qualify for disability. Dr. B informs her that he will not do so because he believes she is capable of employment and that receiving disability would make her less likely to improve. Ms. D and her parents file letters of complaint about Dr. B to the supervisor of the psychiatric clinic for lack of treatment efficacy and for not supporting her disability claim. Dr. B dreads seeing Ms. D on his appointment list, and realizes she repulses him.

Although “the difficult patient” is not a diagnosis or specific clinical entity, clinicians universally struggle with such patients and have an immediate sense of shared experience when describing the phenomenon. In primary care, O’Dowd¹ aptly described this type of patient as the “heartsink” patient, meaning the practitioner often feels exasperation, defeat, or dislike when he or she sees the patient’s name on the schedule.

This article discusses the literature on this topic and provides strategies for dealing with difficult patients in psychiatric practice.

continued



'Difficult' patients

Clinical Point

The best way to develop empathy for a challenging patient is to learn about him as a person and not as a clinical entity

Table 1

Common psychiatric disorders in difficult patients

Multisomatoform disorder
Panic disorder
Dysthymia
Generalized anxiety disorder
Major depressive disorder
Alcohol abuse or dependence*

*Researchers categorized patients as having "probable" alcohol abuse or dependence but did not determine if they met DSM-IV-TR criteria for these disorders

Source: Reference 8

Patient characteristics

Most published reports of difficult patients involve descriptive case series or physician accounts, most often describing patients presenting in nonpsychiatric specialties, including family practice, emergency medicine, rheumatology, gastroenterology, plastic surgery, and dentistry, among others.²⁻⁷

In a survey of physicians in 4 primary care clinics, subjects rated 96 (15%) of 627 adult patients as "difficult."⁸ Difficult patients were significantly more likely than others to have a mental disorder (*Table 1*).⁸ They also had more functional impairment, higher health care utilization, and lower satisfaction with care.

A separate primary care clinic study found uncannily similar results—physicians rated 74 (15%) of 500 new walk-in patients as "difficult."⁹ Compared with other patients, the difficult patients had:

- higher rates of psychiatric illness, somatization (>5 somatic complaints), and more severe symptoms
- poorer functional status, more unmet expectations, less satisfaction with care, and higher use of health services.

In addition, physicians with a "poor attitude" toward psychosocial problems

were much more likely to rate an encounter as difficult.

Fewer articles on difficult patients have been published in psychiatric literature, although some commonalities have emerged (*Box*).¹⁰⁻¹² Often suffering from chronic conditions without well-defined treatment endpoints, difficult patients do worse clinically, have higher use of health services, and are less happy with their care than other patients.

Difficult patients challenge our competence as physicians and evoke personal distress. Physicians with less job satisfaction, less clinical experience, less training in counseling, and a poor attitude toward psychosocial problems are more likely to perceive a patient as difficult.^{13,14}

Survival strategies for clinicians

Eight strategies can help improve your care of difficult patients (*Table 2*).

1. Acknowledge that the patient is difficult. Allowing yourself to acknowledge that the patient is difficult will enable you to exhale and relax in your approach. Denying that you are frustrated can lead to unconscious actions with bad results for the patient. For example, a psychiatrist in denial of his or her aversion to a chronically suicidal patient may unconsciously forget appointments or signal messages of rejection during a session. The patient may consciously or unconsciously sense abandonment, which can precipitate a crisis.¹⁵

2. Develop empathy. Empathy is identification with and understanding of why a person feels, thinks, and acts as he or she does. The best way to develop empathy for a difficult patient is to learn about him or her firsthand—directly from the patient, not from reading chart notes or from information passed among colleagues.

Learning about the patient firsthand means shifting from sign-and-symptom gathering to performing a genuine inquiry about how the person thinks or feels, including interests, loves, or background. Challenging clinical circumstances—such as seeing a patient in a busy emergency

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Why certain patient types evoke negative reactions

An Ovid Medline search of psychiatric literature for “difficult patients” found only 9 articles published from 1996 to 2008, and most were editorials or essays.¹⁰

Groves¹¹ grouped difficult patients into 4 categories:

- dependent clingers
- entitled demanders
- manipulative help-rejecters
- self-destructive deniers.

For a description of the behaviors and personality traits associated with each of these 4 categories and strategies to address them, see “The nurse who worked the system,” CURRENT PSYCHIATRY, July 2009, p. 69-76. Groves emphasized that a physician’s negative reactions evoked by such patients—once understood through introspection—may facilitate better understanding and psychological management in their care.

Hinshelwood¹² wrote about the cognitive dissonance psychiatrists encounter when trying to balance the different responses evoked by patients with schizophrenia and severe personality disorders.

When confronted with a psychotic patient’s severely damaged reality testing, psychiatrists often depersonalize the patient in an effort to be “scientific.” Conversely, patients with severe personality disorders threaten the psychiatrist with their emotional instability. The psychiatrist loses the role of objective observer and instead becomes a “moral evaluator,” seeing the patient as “good” or “bad” instead of as a person in need of help.

Hinshelwood cautioned that patients such as this are difficult not because their treatment is complicated but because they challenge our identity as scientists and put us in personal difficulty.

Clinical Point

Having a team responsible for a difficult patient’s care can diffuse the patient’s dysphoric intensity

department or during a 15-minute medication check—can make this difficult. In some cases, however, the time needed to establish empathy can be surprisingly brief.

When I meet a patient for the first time, I always begin the conversation as if I wanted to write a brief, positive “bio” of who he or she is. This involves purposefully avoiding questions about pathology. First impressions are powerful in guiding future relationships, and clinicians can cultivate empathy in a natural process by learning about the patient as a person and not as a clinical entity.

The more patients feel that the psychiatrist is “on their level,” the less likely they are to project internalized anguish or impulsively act on conflicted feelings.

3. Seek out supervision or consultation.

You can gain new perspectives by taking a “step back” and looking at the case with a colleague. Seeking out consultation also allows you to decompress by “getting it off your chest.” Supervision often allows clinicians to develop:

- empathy toward a difficult patient
- increased energy and creativity in subsequent sessions.

Table 2

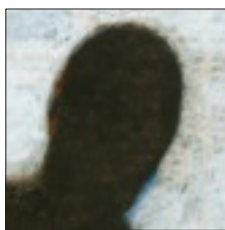
8 strategies for managing difficult patients

1. Acknowledge that the patient is difficult
2. Develop empathy
3. Seek out supervision/consultation
4. Utilize a team approach
5. Lower treatment goals
6. Decompress the treatment timeline
7. Use ‘plussing’ (positive comments and acknowledgements)
8. Use imagery (visualize the patient as a character in an unfinished novel)

4. Utilize a team approach. Difficult patients are exhausting. When possible, having a team rather than an individual responsible for a difficult patient’s care can diffuse the patient’s dysphoric intensity and decrease “targeting” of 1 clinician. In addition, the shared experience of carrying a difficult patient lightens the secondary trauma for individual clinicians.

If you cannot utilize a team to carry out treatment, this approach still may help you develop a treatment plan.

continued



'Difficult' patients

Clinical Point

Lowering treatment goals can help you relax and put you in a better position to help your patients

5. Lower treatment goals. The nature of difficult patients makes complete "cures" a rarity. A psychiatrist whose goal is to substantially help a patient may become chronically frustrated and feel inadequate in the face of a patient's perpetual suffering. The clinician sometimes reacts by developing therapeutic nihilism and withdrawing energy from the case. The patient, of course, senses this and increases his or her general distress level, which intensifies the negative interaction.

By lowering goals—for example, aiming for stabilization rather than improvement—you can feel less like a failure and be more relaxed. A relaxed clinician is more tolerant and in a better position to help the patient. Other lowered goals might be to reduce harm from impulsive or dangerous behaviors instead of eliminating them or better coping with symptoms rather than symptom remission.

6. Decompress the treatment timeline. Difficult patients typically have chronic symptoms that respond poorly to treatment. The clinician who understands that he or she is unlikely to rapidly reduce or

eliminate the patient's symptoms can relax, focus on developing empathy, and help with immediate coping plans that don't focus on solving long-term problems. Visualizing a treatment plan that has years instead of weeks as markers on the timeline can help you accomplish this.

7. Use 'plussing.' Because we experience dread with difficult patients, clinicians often avoid, refrain from, or simply don't see opportunities to use positive comments and acknowledgements ("plussing") when they arise. Most patients (as well as clinicians) want to be liked, and small compliments—when genuinely and appropriately placed—sometimes can make a huge difference in patients' willingness to cope or try new things.

8. Use imagery. Visualize your patient as the central character in an unfinished novel about his or her life. You are in the book as well. Imagine that you are somewhere in the middle of reading this novel. As the once-removed passive reader, you can enjoy the rich, complex nature of the characters and their interactions without feeling

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overwhelmed by responsibility. You are much better able to accept that your patient is just 1 character, influenced by a myriad of factors other than you. As a character yourself, you are keenly aware of your strengths and weaknesses.

This technique might allow you to see the humorous side of yourself as the hard-working, well-intentioned yet ineffectual psychiatrist. You don't know how the story will unfold, but you can accept this as you would in any other unfinished novel.

CASE CONTINUED

A more effective approach

Dr. B realizes Ms. D is a difficult patient for him and takes the case into supervision. He is stunned when he is unable to answer several of his supervisor's questions about Ms. D, including "What was her upbringing like?" and "What are her strengths or interests?" He realizes he knows little about Ms. D and becomes aware that he has focused most of their sessions on either fixing her immediate and never-ending crises or defending himself.

The supervisor points out that Dr. B's lack of empathy for Ms. D keeps him from helping her—being anxious and defensive makes him less likely to be supportive or creative. Dr. B feels better after the supervision session. He experiences some catharsis and develops a plan to improve the situation.

Dr. B structures the next session to get to know Ms. D better. He mentally decompresses the treatment timeline and refocuses on the need to develop empathy instead of attempting to ameliorate symptoms. Dr. B begins by letting Ms. D know he wants to help her but doesn't know much about her. She initially rejects his attempts at empathic communication, but with gentle persistence he learns about her upbringing and interests. Dr. B is able to genuinely compliment her on coping with previous

Related Resources

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Disclosure

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traumas and begins to better understand her strengths. Over the next several weeks, Ms. D seems more able to accept supportive interventions and eventually begins a part-time job.

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Clinical Point

Small, genuine compliments sometimes can make a huge difference in patients' willingness to cope or try new treatment plans

Bottom Line

Relaxing your approach to difficult patients can ease your dread and improve the therapeutic alliance. Develop empathy by getting to know the patient as a person. Set realistic treatment goals, and help with immediate coping plans. Seek consultation and a team approach as needed.