Recognition and Management of the Overly Affectionate Patient

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Physicians should be aware that patients who offer excessive admiration, signs of affection, and flattery are exhibiting a form of seductive behavior. To understand and manage this behavior, the physician must recognize his or her susceptibility to the feelings of omnipotence it engenders. Setting realistic expectations, challenging these patients to be less dependent upon the physician, and recognizing the need for referral in certain situations is necessary in managing such patients. A mature physician strives toward developing self-reliance and independence in patients.

Difficult patients have been defined as those who in some manner upset their physician.[1] Excessively affectionate and adoring patients are difficult without being upsetting. Characteristically these patients offer physicians undue amounts of praise, compliments, and gifts. Such behavior is seduction by flattery. Although this may be less threatening to a physician than other forms of seductive behavior, seduction by flattery can develop insidiously and be difficult to manage. Levin has noted that "physicians are vulnerable in varying degrees to different types of seduction. Some may find erotic seduction not particularly troublesome, but are hard put to cope with the patient who plays upon their wish to be omnipotent, famous, admired or loveable."[2]

Overly affectionate patients are a subtype of a group that Groves has referred to as "dependent clingers."[3] Their need for explanation, affection, medication, and other forms of attention exceed good medical care and often the tolerance of many physicians. Early interactions with such patients stimulate a sense of self-importance in their physicians. Later these patients may exhaust their physician's ability to cope with them. The early sense of omnipotence is then replaced by feelings of weariness and aversion.

Case Report

Mrs. W. is an 83-year-old white woman, divorced since 1942 with two living children, currently living by herself. I first encountered Mrs. W. during residency training and saw her from 1977 through 1979 on nine occasions for a variety of problems: osteoarthritis, mild depression, complaints of dizziness, and treatment of a basal cell carcinoma of the nose, as well as for routine health maintenance. Mrs. W.'s affection for me grew with each visit. Gifts of food and compliments about my great fund of knowledge, my handsome appearance, and my ward manner were increasingly offered.

As many elderly patients do, Mrs. W. sought physical contact. She grasped my hand, embraced me, and kissed me on the cheek. As visits progressed, she even declared her love for me. These efforts at physical contact were either ambivalently supported or ineffectually resisted. Consulting physicians often made remarks about her worshipful attitude toward me. As many of my needs were

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being met by this relationship, I took such comments by my colleagues good naturedly.

In August 1978, a Pap smear taken during a routine health maintenance visit revealed moderate cervical dysplasia. Gynecologic consultation led to a cervical biopsy. Examination under anesthesia revealed a stage IIB carcinoma of the ovary. After uneventful recovery from surgery, Mrs. W. received 12 months of chemotherapy, which she tolerated well. The patient was convinced that I had "saved her from cancer." When Mrs. W. said her gynecologist was annoyed that she gave most of the credit for her recovery to me, I felt a mixture of chagrin, embarassment, and enjoyment.

Despite her poor vision and limited income, Mrs. W. continued to contact me after I entered into private practice in another state. She wrote frequent letters and made occasional long distance telephone calls to my home. According to Mrs. W., it was nothing short of an "act of God" that I later returned to my residency program as a faculty member. At the request of Mrs. W. and her new physician, I again became her family physician.

A presentation of my relationship with Mrs. W., was the subject of a departmental Grand Rounds. Through the preparation and presentation of this conference, I gained new insights into my relationship with Mrs. W. Further awareness resulted from self-reflection, reading, and especially the comments of my colleagues.

On subsequent visits I listened to Mrs. W. and reassured her that I was as available to patients who did not bring gifts as to those who did. She continued to bring gifts, but not so often. When she telephoned me at home, I told her I would accept calls at home only if she felt her problem to be a true emergency. I explained that I needed private time, away from patient responsibility. Afterward she rarely called except when lonely and emotionally upset.

I told Mrs. W. that I was not doing a very good job if she felt she could not get along without me. I told her my goal was for her to be able to function well without having to depend on me. I think she believed me. I felt better about our relationship as a result of these changes. An office visit every six to eight weeks seemed sufficient to provide the recognition and contact Mrs. W. needed during this lonely, frightening period of her life. I was careful to reschedule visits independent of flattering praise or gift giving.

Discussion

Overly affectionate patients usually have an unconscious need for control or recognition.[4] They attempt to control the patient-physician interaction by playing upon the physician's wishes to be admired. The susceptible physician often feels guilty when he or she is unable to meet such patients' needs or demands. Recognition of these feelings and their origin may help the physician appreciate the weakly disguised feelings of loneliness, depression, or even hostility often found in these patients.[5] When the needs of overly affectionate patients go unmet or unrecognized, anger, aggression, and rejection can quickly replace hero worship, flattery, and affection.[6]

Physicians may label as difficult those patients who fail to respond to therapeutic efforts. It is clear there are certain features of physicians that may contribute to these difficulties.[7] A physician's encouragement of overly affectionate behavior may be as unconscious as a patient's motivations for exhibiting this type of behavior. All physicians derive some satisfaction from patient encounters because they meet to some degree the "need to be needed." It is acceptable for a physician to wish that patients develop confidence in him, but it is unacceptable for the physician to wish that patients see him as all-powerful. Curry reminds us, "If one has omnipotent feelings he should reflect upon the rapidity with which patients find other medical services when a physician leaves the community or dies."[8]

It is true that physicians are most successful with patients who admire them. When a physician receives an exaggerated compliment, there is probably no harm in accepting it with reservations, but it should not be swallowed whole. Surely part of the credit belongs to someone else and has been offered to the physician through displacement.[9]

Patients often transfer some part of their own past experience with powerful figures to their relationships with their physicians. Transference is a two-way street. Both patient and physician bring displaced feelings, passions, and attitudes from former emotional attachments into their relationships. The identification and exploration of these transferred feelings has become the basis of many forms of psychotherapy. In family medicine these phenomena are rarely explored formally, but

much frustration can be avoided when it is recognized that they are taking place.

Recognition and Management

Seduction by flattery must be recognized for what it is as it is occurring. The physician should be alert to feelings of omnipotence and a desire for self-importance. Acknowledging these feelings will help the physician to understand why certain patients are special for him or her and others are not.[10] This self-awareness will also help alert the physician to overly affectionate behavior and his or her vulnerability to such behavior.

When a physician leaves a patient encounter and feels the patient has been let down, he should consider that he may be encountering overly affectionate behavior in a seductive patient. This physician should examine his guilt feelings to see if they stem from trying to meet unrealistic patient demands.

Once seduction by flattery is suspected or recognized, several specific tactics are appropriate.

The physician should comment on the flattering behavior of the patient. This will help to clarify the relationship. Although there is a chance that a patient will be unaware of this behavior and feel put off by such a confrontation, it is a risk worth taking.[11]

The physician should be honest and set limits, explaining to the patient the boundaries of one's ability to meet such needs and demands. Lowering patient expectations to a realistic level is a good way to avoid mutual frustration and disappointment.[12,13]

The physician should challenge his patient to become less dependent upon him, pointing out that he may have failed as a health educator if the patient becomes too dependent upon advice, visits, or medications. An overly affectionate patient wishes to please the physician and may respond constructively if guilt feelings are aroused by understanding they are not meeting the physician's expectations. In this way the patient is encouraged to share responsibility for the patient-physician relationship.

Regularly spaced office visits not dependent upon praise or the degree of somatic complaints are useful. Such visits demonstrate physician concern for the patient independent of symptoms or flattering remarks and may help to reduce reinforcement of this behavior.

Finally, if the physician's feelings, whether positive or negative, are interfering with his ability to serve the patient optimally, it is time to consider consultation or referral to a trusted colleague.

Conclusion

It is important for the family physician to recognize and correctly manage the seductive behavior of overly affectionate patients. An awareness that excessive flattery and guilt engendering behavior are forms of seductive behavior is essential. The physician needs to recognize a susceptibility to feelings of omnipotence and a vulnerability to seduction by flattery. Clarification, challenge techniques, limit setting, and consultation can be used in dealing with overly affectionate behavior. Finally, the physician must understand that an overly dependent, adoring patient is indicative of a physician need as much as a patient need. True healing is closely linked to patient self-reliance.

References

1. Steiger WA: Managing difficult patients. Psychosomatics 8:305, 1967.
2. Levin L: Roundtable. Dealing with the seductive patient. Med Aspects Hum Sexual 10:90, 1976
3. Groves JE: Taking care of the hateful patient. N Engl J Med 298:883, 1978
4. Von Mering O, Earley LW: The ambulatory problem patient: A unique teaching resource. Am J Psychiatry 126: 108, 1969
5. Lurie JH: Clinical Psychiatry for the Primary Physician. Nutley, NJ, Roche Laboratories, 1976, pp 66-70
6. Steiger WA, Hanson AV: Patients Who Trouble You. Boston, Little, Brown, 1964, pp 46-50
7. Steiger WA, Hirsh H: The difficult patient in everyday medical practice. Med Clin North Am 49:1440, 1965
8. Curry HB: MD: No substitute for selfhood. J Fam Pract 6:1167, 1978
9. Byrd B: Talking With Patients. Philadelphia, JB Lippincott, 1973, pp 59-66
10. Hackett TP: Which patients turn you off? It's worth analyzing. Med Econ 46:94, 1978
11. Hollender MH, Shevitz S: The seductive patient. South Med J 71:776, 1978
12. Murphy GE, Guze ST: Setting limits: The management of the manipulative patient. Am J Psychotherapy 14: 30, 1960
13. Malcolm R, Foster HK, Smith C: The problem patient as perceived by family physicians. J Fam Pract 5:361, 1977