MANAGING THE DIFFICULT PATIENT: TIPS OUTSIDE THE MEDICAL MODEL

I HATE THIS PATIENT

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Disclaimer

- This talk is from the provider perspective and not from the patient perspective.
- Comments are my own and are designed to be provocative.
- There is a sister talk about the "Difficult Provider".
- I acknowledge that when providers walk into the encounter we carry our own "packed bag" of personal issues and experiences!

Learning Objectives

- Understand common types of difficult patients.
- Match patterns of patient behaviors to identify these difficult patient typologies.
- Understand Countertransference and Projective Identification
- Learn how difficult patients affect the provider.
- Learn specific tools in working with these patient types.
- Learn how to be less troubled by these encounters.

OVERVIEW

- TYPES OF DIFFICULT PATIENTS
- FINDINGS ABOUT DIFFICULT PATIENTS
- DEFINITIONS OF TERMS
- COUNTERTRANSFERENCE AND PROJECTIVE IDENTIFICATION
- CASES/ TECHNIQUES IN MANAGEMENT

What do we want from a patient encounter?

- What do you personally hope to get out of a patient encounter?
- How do you feel a sense of accomplishment and reward from the encounter?

What do you want out of a rewarding patient encounter?

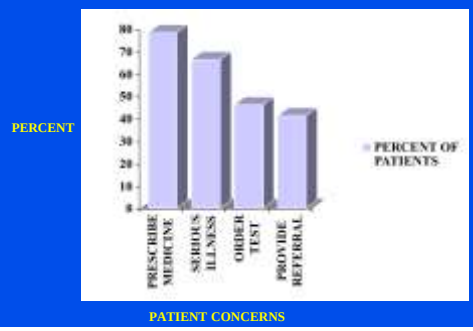
- Help the patient
- Detect the problem
- Fix the problem
- Feel good about the encounter
- Like the patient
- Have a "connection"
- Understand where they are coming from
- Feel appreciated for your efforts
- Feel a sense of accomplishment
- Get to the bottom of their complaint
- Get out quickly
- Do something that can change their life.
- Learn something new.

What does a provider want?

- Providers generally want a sense of closure and satisfaction with their practice
- Providers hope for an appreciative, cooperative patient.

What do you think the patient wants to get out of the encounter?

PATIENT EXPECTATIONS



"Overwhelmed"- CASE 1

- A 44-year-old female with **screening form**- vague chronic pelvic pain, tingling in her scalp, headaches, allergies, poor sleep, fatigue, non exertional chest pain, shortness of breath, knee pain, bowel disturbances, dizziness.

- Vague descriptions
- Scattered
- Very distressed by her symptoms.
- Wants all addressed as lives hour away

Feelings/ Countertransference?

- How might you feel about this patient?
- Do you feel that you could possibly be satisfied after seeing this patient?

Feelings/ Negative Countertransference

- Dread
- Overwhelmed.
- Frustration
- Pressed for time
- Anger
- Powerless to help

DIFFICULT PATIENT

- Osler-- never mentioned.
- Harrison's and Cecil's Textbook of Medicine do not acknowledge these patients.
- Many Med Schools do not have this yet in their curricula.

SYNONYMS FOR DIFFICULT PATIENTS

- HATEFUL PATIENTS
- PROBLEM PATIENTS
- TROUBLESOME PATIENTS
- HEARTSINK PATIENTS
- BLACK HOLES
- CROCKS
- TURKEYS
- GOMERS
- DYSPHORIC PATIENTS
- THICK-CHART PATIENTS
- HYPOCHONDRIACS
- WORRIED WELL

SUBTYPES OF DIFFICULT PATIENTS

- ANGRY/ ENTITLED/THREATENING
- COMPLIMENTING
- TOO MANY COMPLAINTS
- SOMATIZERS
- DEPENDENT/ “CLINGERS”
- UNEXPLAINED SYMPTOMS
- ANXIOUS
- DENIERS/ NON COMPLIANT

FINDINGS

- Approx. 17-30 percent of patients are difficult.
- Increased number of complaints.
- One-seventh of patients account for ½ of all doctor-patient encounters.

FINDINGS

- Thicker chart
- Older
- More are widowed, divorced
- More medicines
- Lower social class and socioeconomic status
- More psychosocial problems

"You'd charge a lot too, if you had to look at people like you naked all day."

TERMS

- Countertransference
- Projective Identification
- Containment

COUNTERTRANSFERENCE

- Feelings evoked in the doctor by the patient:
  - The doctor's personal history/ past
  - Evoked reactions to behaviors (verbal or non-verbal)

HISTORY OF COUNTERTRANSFERENCE

- Term coined by Sigmund Freud
- Initially viewed as the "patient's influence on the analyst's unconscious."
- He thought that any feelings toward the patient should be eliminated by the analyst's self-control.

COUNTERTRANSFERENCE

- STRONG FEELINGS EVOKED IN THE PROVIDER.

BACK TO OUR PATIENT…

"Overwhelmed"- CASE 1

- A 44-year-old female with **screening form**- vague chronic pelvic pain, tingling in her scalp, headaches, allergies, poor sleep, fatigue, non exertional chest pain, shortness of breath, knee pain, bowel disturbances, dizziness.

What to do?

- Do you think they have somatization (Somatic Symptom Disorder- DSM-V)?

- Can a primary care doctor diagnose somatization?

Diagnosis of Somatic Symptom Disorder

- A dilemma for psychiatrists
- Now the diagnosis is in the hands of primary care doctors

How is DSM-5 Different?

- The Old DSM-IV diagnosis of somatization disorder required a specific number of complaints from among four symptom groups. (4 pain, 2 GI, 1 Sexual, 1 pseudoneurologic) and exclusion of organic cause.
- The SSD criteria no longer have such a requirement.

How is DSM-5 Different?

- Somatic symptom disorder (SSD) is characterized by somatic symptoms that are either very distressing or result in significant disruption of functioning.
- Excessive and disproportionate thoughts, feelings and behaviors regarding those symptoms.
- To be diagnosed with SSD, the individual must be persistently symptomatic (typically at least for 6 months).
- At least age 30.

How is DSM-5 Different?

- While DSM-IV Somatization disorder was organized centrally around the concept of medically unexplained symptoms, DSM-5 criteria instead emphasize the degree to which a patient's thoughts, feelings and behaviors about their somatic symptoms are disproportionate or excessive.

RULE

- You must make a reasonable attempt to rule out organic causes… even for somatization/ SSD patients. Even if SSD does not require rule out of organic causes.

Feelings

- What would you do to treat this patient?

STRATEGIES

- Set clear boundaries up front
- “What else” technique
- Agenda set
- Define patient and provider expectations
- Set future appointment schedule.
- Document what you plan on accomplishing next visit.
- Give patient homework assignments

SOMATIZERS

- Set limits
- Set regular, time limited visits and decrease the frequency as time goes on.

Question

- Do you think that reassurance will allay the anxiety in this patient?

Pearl

- Explore depression in these patients.

Question?

- Would you explore the significance of the symptoms for the patient using the psychosocial approach?
- What do you fear might happen if you did?

Optional Slide- What can happen when provider takes a psychosocial approach…

- Providers want to get to the bottom of the MEDICAL problem. This is a psychologically based issue.
  - Providers want a sense of closure and satisfaction with their practice (Medically)- Switch to having a psychological satisfaction of making the diagnosis and affect treatment.
  - Providers hope for an appreciative, cooperative patient. Rarely are these patients.

PSYCHOSOCIAL PROBLEMS

- Many doctors feel uncomfortable with addressing these problems.
  - Take too much time or effort
  - Uncomfortable with the treatment
  - Fear of rejection by patients
  - Fear being too intrusive
  - Fear the patient will reject the psychiatric consult
  - Fear of accumulation of these patients in practice.

What can happen when provider takes a psychosocial approach…

- Negative
  - Patients feel rejection (all in the “head”)
  - Patients may feel their PHYSICAL problems were not addressed.
  - They feel the provider is not listening.
  - Run out of time during the encounter
  - Push the patient away by adapting a psychosocial approach for a patient who is not able to handle it or insightful enough.

What can happen when provider takes a psychosocial approach…

- Positive
  - May uncover the reason or meaning for symptom
  - How the problem effects the patients life
  - What the patient thinks it is
  - Underlying mood disorder or personality disorder
  - Establish rapport and trust.
  - Feel the doctor cares and is invested.

Risk

- Moving too quickly to complete psychosocial approach-
  - Eliciting meaning of the symptoms is important but can annoy certain patients.
  - View that you are rejecting them/ think that all is in their head.

COMMON SOMATIZATION SYMPTOMS

- **Most common**-
  - Musculoskeletal
  - Gastrointestinal
  - Cardiovascular
  - Neurological
- **Least common**-
  - Dermatological
  - ENT
  - Genitourinary

NEMESIS OF EACH SPECIALTY

- Gastroenterology– Irritable Bowel Syndrome
- Neurology– Dizziness
- Gynecology– Pelvic Pain
- Rheumatology– Fibromyalgia
- Surgery– Abdominal Pain
- All– Fatigue, Atypical Chest Pain, Headache

TECHNIQUES

- Be aware of your own, possibly preconscious, belief systems and how they can be a hindrance to care for this patient.
- Identify the behavior in the patient and call him on it.
- Listening, empathy, compassion

"I'M CUTTING YOU OFF"

TECHNIQUES

- Symptom diaries.
- Set limits
- Cognitive Behavioral Therapy
- Consider collaborative stepped care.

COLLABORATIVE STEPPED CARE

- Bringing to bear multiple services under the leadership of Internal Medicine or Family Practice.
- Effective for patients with multiple unexplained symptoms and somatizers.

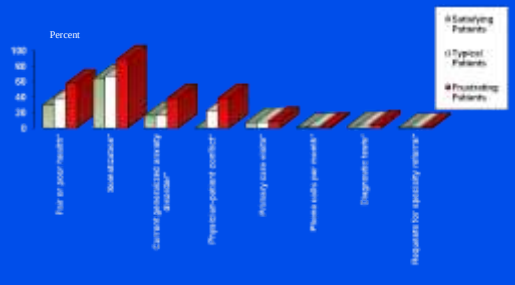
Pearl

- Be aware of how you are feeling about the patient.
- Provide truthful medical reassurance if possible.
- Look at patient with compassion, this may decrease negative countertransference.

FRUSTRATION

- Frustration is the most common feeling in doctors dealing with the difficult encounter.

Frustrating Patients



* Reached statistical significance P< 0.05

Received from the Center for Health Studies, Group Health Cooperative of Puget Sound, Department of Health Services, University of Washington School of Public Health (EHBL, MVK, TB, EW) and the Department of Psychiatry and Behavioral Sciences, University of Washington Medical School (WK, PL, JR), Seattle, Washington.

"Doc, please don't be too aggressive, I'm kinda attached to my symptoms"

CASE

- A 42 yo M with blank, expressionless stare, subdued voice. He was referred for chronic back pain with some bony pain.
- Answers simply "yes" or "no".
- Records note high level of health care use, multiple medical providers.
- Vague symptoms, limited responses.
- Notes that "I don't even know why I am here… I don't feel you can even help me."

Your response

- You went in feeling good and walked out drained, discouraged, helpless and annoyed.
- What happened?

What Happened?

- Projective Identification-
  - The negative emotions (depression, fatigue, anhedonia) were projected subconsciously onto the object (provider).
  - The provider is left with feeling drained.

TERMS

- Countertransference
- Projective Identification
- Containment

RULE

- ASSESS PATIENT FOR DEPRESSION AND PSYCHIATRIC ILLNESS

FINDINGS ABOUT DIFFICULT PATIENTS

- More psychiatric illness (> 60%)
  - Depression
  - Anxiety/ Panic
  - Alcohol and drug abuse
  - Somatization

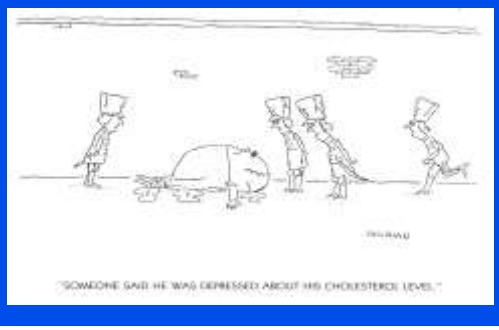
FINDINGS

- Only 1% of patients presenting with physical symptoms were initially willing to consider a psychiatric explanation for their symptoms.

FINDINGS

- In a seminal study by Kaufman and Bernstein, 814/1000 in-patients with unexplained symptoms and no discovered organic illness.
- These patients had a psychiatric diagnosis as either the primary or secondary diagnosis. (81.4%)

"SOMEONE SAID HE WAS DEPRESSED ABOUT HIS CHOLESTEROL LEVEL"



FOUR TYPES OF PATIENTS BY GROVES

- ENTITLED DEMANDER
- DEPENDENT CLINGER
- MANIPULATIVE HELP REJECTOR
- SELF DESTRUCTIVE DENIER

THE ANGRY/ HOSTILE-ENTITLED DEMANDER

THE ANGRY/ HOSTILE PATIENT

- Mr. A is a 48 yo male- HTN, Lower Back Pain
- Introduction he notes," I have been waiting 30 minutes to see you!"
- He is angry and agitated.
- Negative body language.
- Had requested MRI of spine prior to appt.
- He notes, "I have another appt. in 20 minutes and I'm always on time to my appointments."

FEELINGS

- ANGER
- AVERSION
- ANXIETY
- FEAR
- FRUSTRATION
- DESPAIR
- MALICE
- INADEQUACY/ HOPELESSNESS
- GUILT

ANGRY HOSTILE PATIENT

WHAT DO YOU DO?

a) STAND UP TO HIM. YOU DON'T DESERVE TO BE MISTREATED.
b) REMOVE HIM FROM YOUR PRACTICE
c) REFER HIM TO SOMEONE ELSE
d) ORDER THE MRI, LIFE'S TOO SHORT
e) OTHER

Pearl

- Never lose your temper or yell at a patient
- Meticulous documentation is required
  - Record everything that happened
  - Note witnesses to the behavior
  - Keep a paper trail if behavior is recurrent, consider including your feelings

Pearl continued

- Never be coerced into doing anything that is not medically indicated (i.e. surgery or MRI)
- Remember that each of those past relationships probably began the same way as this one.
- Talk about/ vent your experiences with a colleague to avoid acting out on negative feelings

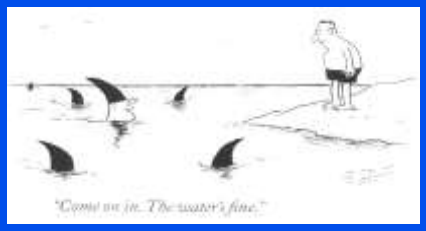
ANGRY PATIENT

- TECHNIQUES
  - "I- STATEMENTS"
  - "FEEDBACK SANDWICH"
  - MIRRORING
  - REFLECTIVE LISTENING

ANGRY PATIENT

- PATIENTS OFTEN FEEL OUT OF CONTROL… WANT TO MAKE THE PROVIDER FELL AS HELPLESS AS THEY DO

"Come on in. The water's fine."



ENTITLED DEMANDER

- They attempt to gain control over their doctors by intimidation, devaluation, or guilt.
- May threaten litigation.
- Have deep dependence on doctor (but unaware of it).

ENTITLED DEMANDER

- Don't act on your strong counter-transference.
- Be aware of their entitlement.
- Gain empathy for their situation.
- Discuss case with trusted colleague

"Your problems make my fee seem insignificant"

Reality Check

- "YOU HAVE AN OBLIGATION TO CARE FOR YOUR SHARE OF THESE DIFFICULT PATIENTS"

– **MICHAEL F. LUBIN, M.D.**, EMORY UNIVERSITY SCHOOL OF MEDICINE, *HANDLING THE DIFFICULT PATIENT*, AMERICAN COLLEGE OF PHYSICIANS ANNUAL SESSION; 2003, 1-20.

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DEPENDENT CLINGER

DEPENDENT CLINGER

- 32 YO attractive M/ F with intermittent diarrhea.
- You diagnose him/ her with mild dumping syndrome from him/her childhood bowel surgery
- Explain what this is and how to treat.
- He/ She thanks you, is appreciative, and compliments your fine diagnostic acumen.

What is the countertransference?

DEPENDENT CLINGER

- May initially compliment doctor's skill
- Appeals to his/her need for affirmation, and appreciation
- Doctor feels good about encounter

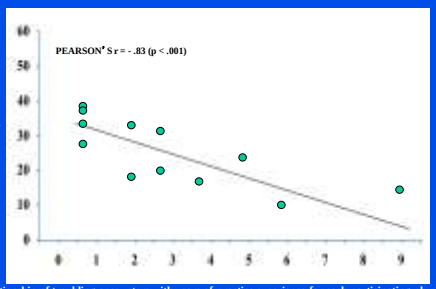
DEPENDENT CLINGER

- May call or email doctor frequently
- Wants frequent appointments
- Gains dependency on the provider
- Neediness progresses

DEPENDENT CLINGER PEARL

- Recognize the earliest signs of dependency and *set firm limits*.
- Be aware of how your counter-transference has changed.
- Humanize your abilities and limits.
- Communicate your perceptions.

YEARS OF PRACTICE EXPERIENCE



Relationship of troubling encounters with years of practice experience for each participating physician.

Received from the Department of Family Practice, University of California, Davis, Sacramento, California, and the Department of Family Medicine, Faculty of Medicine, University of Western Ontario, London, Ontario. Requests for reprints should be addressed to Dr. James E. Coulter, Department of Family Practice, University of California, Davis, 2221 Stockton Boulevard, Room 13, Sacramento, CA 95817.

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MANIPULATIVE HELP REJECTER

MANIPULATIVE HELP REJECTER

- 75 yo WF with recurrent complaint of a "trickling/burning" sensation localized to her groin.
- She describes the sensation as a feeling of hemorrhaging.
- CT scan not completed to look for missed hernia
- 4 referrals for colonoscopies delayed

MANIPULATIVE HELP REJECTER

- Negative office GYN evals
- ABI's not completed.
- Meds not effective x3
- No providers have been able to help.

Pearl

- "When a patient badmouths all prior doctors, watch out, you're next!"
  - Ellwood Jones, MD, FACP
  - Professor
  - UT Southwestern

MANIPULATIVE HELP REJECTER

- Something is wrong, but nothing has helped her.
- You mentioned you are out of ideas and confront her that she has not followed your advice.
- Pleads with you: "Please don't give up on me; all other doctors have given up on me. You are my last hope."

MANIPULATIVE HELP REJECTER

- They believe that no recommendation, treatment, or regimen will help them.
- Report that, once again, the treatment failed.
- They seek to maintain the doctor-patient relationship.
- Are dependent and often depressed.

MANIPULATIVE HELP REJECTER

- Countertransference
  - Anxiety/ fear that dx has been missed.
  - Self-doubt
  - Irritation
  - Depression
- Projective Identification
  - Helplessness
  - Depression
  - Dependency

MANIPULATIVE HELP REJECTER

- Emphasize- no cure for their condition.
- Regular follow-up visits.
- Allay their fear of abandonment.

"I'd like to talk about my abandonment issues"

MANIPULATIVE HELP REJECTER

- SUBTYPES-
  - NON-COMPLIANT
    - Subconscious disbeliever
  - REFUSNIK

SUBCONSCIOUS DISBELIEVERS

Subconscious Disbeliever

- Joe is a 52 yo WM with several visits where he returns to clinic having not followed through on your recommendations.
  - Went off his BP meds more than once
  - Did not get his stress test
  - Failed to follow through on his colonoscopy.
- Each time he agrees to complete them after a long discussion

SUBCONSCIOUS DISBELIEVER

- You must explore if other reasons for non compliance.
- Explore the patient's beliefs about their illness.
- Tap into their beliefs to "reframe" these beliefs.

Pearl

- Patient *non-compliance or poor adherence* to your prescribed regimen should not affect your ego or self-esteem.
- *Explore the meaning* of the symptom, patient background, and experience.

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SELF-DESTRUCTIVE DENIER

SELF-DESTRUCTIVE DENIER

- 51 yo homeless M mumbling, hallucinating
- History of cirrhosis, Hep C, and varices
- Fifth visit this month
- Has headache and stiff neck
- Refuses a CT scan and LP

SELF-DESTRUCTIVE DENIER

- Are bent on their own self-destruction.
- Doctors feel hate toward them.
- May feel like they would better off be dead (then feel guilty).
- Difficult to treat.
- Explore their views about death.

Pearl

- Make sure the patient has decision making capacity.
- Spend as much energy on your alliance with the family, as on your alliance with the patient. They have the best chance of ever effecting change.

Questions