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SPECIAL ARTICLE

TAKING CARE OF THE HATEFUL PATIENT

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Abstract "Hateful patients" are not those with whom the physician has an occasional personality clash. As defined here they are those whom most physicians dread. The insatiable dependency of "hateful patients" leads to behaviors that group them into four stereotypes: dependent *clingers,* entitled *demanders,* manipulative *help-rejecters* and self-destructive *deniers.*

The physician's negative reactions constitute important clinical data that should facilitate better understanding and more appropriate psychological management for each. Clingers evoke aversion; their care requires limits on expectations for an intense doctor-patient relationship. Demanders evoke a wish to counterattack; such patients need to have their feelings of total entitlement rechanneled into a partnership that acknowledges their entitlement — not to unrealistic demands but to good medical care. Help-rejecters evoke depression; "sharing" their pessimism diminishes their notion that losing the symptom implies losing the doctor. Self-destructive deniers evoke feelings of malice; their management requires the physician to lower Faustian expectations of delivering perfect care. (N Engl J Med 298:883-887, 1978)

ADMITTED or not, the fact remains that a few patients kindle aversion, fear, despair or even downright malice in their doctors. Emotional reactions to patients cannot simply be wished away, nor is it good medicine to pretend that they do not exist. Doctors cannot avoid occasional negative feelings toward the "obnoxious patient,"[1] the whining "self-pitier"[2] or the help-rejecting "crock."[3] Like that of Faust, the doctor's ideal is to "know all, love all, heal all,"[4] but when this ideal of the perfect physician collides with the quotidian realities of caring for sick and troubled patients, a number of processes may ensue: there may be "helplessness in the helper"[5]; there may be unconscious punishment of the patient[2]; there may be self-punishment by the doctor[4]; there may be inappropriate confrontation of the patient[6]; and there may be a desperate attempt to avoid or to extrude the patient from the care-giving system.[7,8]

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A 51-year-old attorney specializing in medical negligence was enraged when his many complaints were ultimately diagnosed as multiple sclerosis. Known for his flashy wardrobe and courtroom pyrotechnics, he roamed from doctor to doctor, refusing to understand the nature of his illness and threatening to sue the previous "bastard" who had tried to help him. He was like Job (xiii:4), who raged, "ye are forgers of lies, ye are all physicians of no value." He adamantly refused treatment and demanded more and more tests and consultations. Eventually, his doctors did not return his calls for appointments and were frightened and depressed about him. How long this situation might have continued is not known, because at this point — to the relief of all concerned — he was stopped by an exacerbation of his demyelinating process that required hospitalization in a chronic-care facility.

This vignette illustrates a "hateful patient" — one whom most physicians would dread to treat. The present communication addresses "countertransference" feelings toward the patient, except for two situations that are thoroughly treated elsewhere: feelings toward the obviously suicidal patient[4]; and idiosyncratic bias reactions confined to a particular doctor with certain kinds of patients.[2,9] The latter group of reactions is determined by specific psychologic processes (usually unconscious) in one doctor; in such a case, the remedy of transferring the patient may well be appropriate, since the idiosyncrasies of one physician are not highly likely to be those of another. Here, discussion will center on patients for whom most physicians would harbor negative feelings and for whom transfer is not usually helpful to the patient.

Hate in the Literature of Medicine

The medical student and the doctor find little help in the literature. Even Osler fails in this regard. Nowhere in his *Principles and Practice of Medicine*[10] does he allude to personal feelings that the difficult patient may stir up; his other writings[11,12] are sermons, more inspirational than practical. Modern textbooks of medicine have a few pages on the doctor-patient relationship,[13,14] but their most negative appellation for a patient is "exasperating,"[15] and they generally suggest that the physician disown negative feelings in favor of integrity, truth, humor and compassion. Psychiatry too, with certain notable exceptions,[2,3,9] has failed to help the rest of medicine with the feelings that patients stir up; even when feelings are addressed directly,[16] the advice tendered is most likely to be, transfer to a colleague who can stand the patient. This gap is particularly odd because psychiatry has been fascinated with the negative side of the doctor-patient relationship since the turn of the century.

"Countertransference" is the word that Freud coined to mean emotional reactions to a patient that are determined by the psychoanalyst's own unconscious conflict. Later on, "countertransference" assumed for some a broader meaning of unconscious and conscious unbidden and unwanted hostile and sexual feelings toward the patient — feelings that were seen to impede the treatment and to reflect poorly on the analyst. Although Freud himself was rather candid about his own countertransference reactions, his scientific attitude about it was often difficult for his early followers to emulate.

In 1949 the prestigious *International Journal of Psycho-Analysis* published a paper written by a pediatrician and psychoanalyst named D. W. Winnicott and entitled "Hate in the Countertransference."[17] In it he acknowledged outright hatred for some patients in certain circumstances. This hatred — and even the murderous wishes associated with it — he compared with the occasional inevitable dislike of the normal mother for her demanding infant. He noted that the apparent innocence of nursery rhymes and lullabys betrays such hatred mixed with maternal love ("Down will come baby/Cradle and all"). The publication of "Hate in the Countertransference" was a benchmark in the study of such feelings; subsequently, papers about countertransference were less defensive. Such feelings have gradually come to be regarded not only as a painful visitation but also as a necessary clue guiding the psychiatrist's conceptualization and technic. Likewise, the study of countertransference phenomena can guide other physicians, especially in the management of four classes of patients: dependent *clingers;* entitled *demanders;* manipulative *help-rejecters;* and self-destructive *deniers.* At times, a single patient may epitomize more than one of these classes. The following portraits are stereotypes.

Dependent Clingers

Clingers escalate from mild and appropriate requests for reassurance to repeated, perfervid, incarcerating cries for explanation, affection, analgesics, sedatives and all forms of attention imaginable. They are naïve about their effect on the physician, and they are overt in their neediness. They may have no discernible medical illness, or they may have severe, chronic or life-threatening disorders; but whatever their medical problems, what is common to them as a group is their self-perception of bottomless need and their perception of the physician as inexhaustible. Such dependency may eventually lead to a sense of weary aversion toward the patient. When the doctor's stamina is exhausted, a referral for psychiatric examination may be adamantly put forth in frustrated tones that the patient (correctly) interprets as rejection. Psychiatric referrals made in this context are destined to fail utterly.

A 23-year-old "exotic dancer" of no little beauty consulted a resident in medicine because of fatigue. This male resident was eventually able to make the diagnosis of lupus. He took care in explaining the mild nature of her particular course. She responded intelligently with questions pertinent to prognosis and eventually asked him whether he would follow her, long-term, for this chronic illness. Flattered and touched, he vowed to do so. Later that day she telephoned briefly to thank him.

During the next week she visited with a question about her medication. In the following week she called twice, once professing great fear that she would die and another time to thank him again. As weeks passed, her calls and visits became more frequent, and her thanks dwindled to nothing. He began to dread her calls.

By the end of two months she was calling him daily, in the office and at home. What had begun as a minuet ultimately became a fandango. He changed programs; she soon was involved in a similar situation with another resident in the same clinic.

Early signs of the clinger are the patient's genuine gratitude, but to an extreme degree, and the doctor's feelings of power and specialness to the patient, an emotion not unlike puppy love. Later on, the doctor and the patient have different feelings toward each other. The doctor becomes the inexhaustible mother; the patient becomes the unplanned, unwanted, unlovable child. Early identification of this situation is helpful, but its corrective may be applied — if done skillfully — at any point short of a complete blowup. The clinger must be told as early in the relationship as possible, and as tactfully and firmly as possible, that the physician has not only human limits to knowledge and skill but also limitations to time and stamina. Written follow-up appointments are placed in the patient's hand, the doctor says, "so long," and never, "good-bye," and the patient is firmly reminded not to call except during office hours or in an emergency. This approach is not cruelty or rejection. It is in the best interest of patient care to protect the patient from promises that cannot be kept and from illusions that are bound to shatter.

Entitled Demanders

Demanders resemble clingers in the profundity of their neediness, but they differ in that — rather than flattery and unconscious seduction — they use intimidation, devaluation and guilt-induction to place the doctor in the role of the inexhaustible supply depot. They appear less naïve about their effect on the physician than clingers and buttress their hold on the doctor by threatening punishment. The patient may try to control the physician by withholding payment or threatening litigation. The patient is unaware of the deep dependency that underlies these attacks on the doctor. The physician, in turn, does not recognize that the hostility is born of terror of abandonment. Moreover, such patients often exude a repulsive sense of innate deservedness as if they were far superior to the physician. This attitude is to shield them from awareness that the physician seems to have power over life and death. Obviously, this sense of innate and magical entitlement to everything that is wanted is depressing (and therefore often enraging) to the busy physician, who may have had to surrender many dreams of omnipotence and omniscience over the years of training. The physician becomes fearful about reputation, enraged that the patient is not cooperative and grateful and — eventually — secretly ashamed, as if the patient's devaluating demands were realistic. But this very "entitlement," repulsive as it may be, is resorted to by the patient in an effort to preserve the integrity of the self in a world that seems hostile or during an illness that seems terrifying. "Entitlement" serves for some persons the functions that faith and hope serve in better adjusted ones. The usual impulse toward entitlement is a wish to point out suddenly and devastatingly that the patient has earned little, medically or in larger society, and deserves little. But this course would be an assault on the very psychologic foundations that support such a patient. Entitlement is such a patient's religion and should not be blasphemed.

Because the lawyer with multiple sclerosis in the first vignette was entitled, he was vulnerable to counterattack. But because he had so much actual power to harm his caregivers, counterattack did not in fact occur. Because his terror and entitlement were concealed beneath the trappings of real achievement, neither was his bombast recognized for what it was — a pathetic sham. Thus it was not addressed in service of the patient's best interest. The physician should never gainsay the patient's entitlement. The most helpful therapeutic strategy with the entitled demander is to support the entitlement but to rechannel it in the direction of the indicated regimen. His doctor might have said,

I know you're mad about this and mad at the other doctors. You have reason to be mad. You have an illness that makes some people give up, and you're fighting it. But you're fighting your doctors too. You say you're entitled to repeated tests, damages for suffering and all that. And you are entitled — entitled to the very best medical care we can give you. But we can't give you the good treatment you deserve unless you help. You deserve a chance to control this disease; you deserve all the allies you can get. You'll get the help you deserve if you'll stop misdirecting your anger to the very people who are trying to help you get what you deserve — good medical care.

Such an approach acknowledges the patient's entitlement — not to have unreasonable demands met or to bully others but to what is realistically good care. The physician must be aware of the litigiousness of such patients and may to a certain extent practice "defensive medicine," but need not be bullied or actually defensive. The doctor also should beware of getting entangled in complicated logical (or illogical) debates with the patient. Rather, there should be tireless repetition of the theme of acceptance that the patient deserves first-rate medical care.

Manipulative Help-Rejecters

Help-rejecters, or "crocks,"[3] are familiar to every practicing physician. Like clingers and demanders, they appear to have a quenchless need for emotional supplies. Unlike clingers, they are not seductive and grateful; unlike demanders they are not overtly hostile. They actually seem the opposite of entitled; they appear to feel that no regimen will help. Appearing almost smugly satisfied, they return again and again to the office or clinic to report that, once again, the regimen did not work. Their pessimism and tenacious nay-saying appear to increase in direct proportion to the physician's efforts and enthusiasm. When one of their symptoms is relieved, another mysteriously appears in its place. Apparently, what is sought is not relief of symptoms. What is sought is an undivorcible marriage with an inexhaustible caregiver. Such patients seem to use their symptoms

as an admission ticket to a relationship that cannot be sundered so long as symptoms exist. Thus, they are often accused of "masochism" and are said to be reaping unjustified "secondary gain." Such patients frequently deny being depressed and typically refuse referral to a psychiatrist. Lipsitt[3] records the case of one such patient who had 10 operations in 12 years, multiple visits to a dozen clinics and a chart that was four volumes long. "Only once was the term depression mentioned in...her record and that appeared in ...1956," some 13 years after she had begun her hegira. Another patient whom he studied had 829 visits to 26 clinics in 36 years; she "said of herself, 'I have a *bissel* of *tsuri*'" (a smidgin of trouble).

These behaviors elicit first in the physician anxiety that a treatable illness has been overlooked, next irritation with the patient and, finally, depression and self-doubt in the doctor. But the depression originally is not in the doctor — it is usually in the patient. Although it is important to suspect depression in the help-rejecter, it is hazardous to imply that he or she is too dependent or immature to get better or that unconscious manipulation is going on. Such an approach simply precipitates a new round of doctor-shopping. Rather, it may be helpful to "share" the pessimism — to say that the treatment may not be entirely curative. Even if it is, regular follow-up visits (hence, at intervals determined by the doctor) are put forth as necessary for the maintenance of any modest gains. In this way, the patient's fear of losing the doctor may be partly allayed, and the patient may be able to follow the treatment plan without fear of engineering his or her own abandonment.

Pathologic dependency presents in one of its extremes as *manipulativeness* — an intense, covert, contradictory, self-defeating attempt to get needs met. It is the behavioral manifestation of a need by the patient to get close to but at the same time to maintain safe distance from sources of emotional support. (Occasional patients feel so empty that, paradoxically, to get needs met threatens them with engulfment; they are so famished that closeness may actually make them feel merged with someone else and therefore not really alive.) Such patients seem to have a deathly fear of that which they most crave[8]:

A young woman in her twenties was hospitalized for control of brittle diabetes mellitus. Cachectic and hateful, she appeared to drive people away. She had a long history of psychiatric hospitalizations, multiple suicide attempts, abysmal relationships and an implacable resistance to co-operating in the management of her illness. Yet she clung to hospitalization. On the day before discharge she simultaneously infected her intravenous lines with feces and spiked a high temperature and threatened to sign out against medical advice. Raging and septic, she had to be physically restrained from leaving prematurely.

The remedy here is not to interpret the pathologic "solution" to the "need/fear dilemma," which is unconsciously being acted out by the patient. Such an action would be useless and harmful. Rather, limits on unrealistic expectations, limits on demanding hostility and — most of all — repeated appeals to entitlement are again invoked. The doctor, by a consistent, firm manner, conveys that the patient will not be allowed to become so close as to be engulfed nor so distant as to starve. Gentle, simple reasoning with this patient is better than complicated explanations.

To refer help-rejecters for psychiatric evaluation is never easy. If a psychiatric illness is thought to be present, one tactic for helping the patient accept psychiatric consultation is to schedule another appointment with the patient for a time after the consultation is to occur. In this way, the doctor can convey that the consultation is an adjunct to medical treatment, not abandonment.

Self-Destructive Deniers

Self-destructive deniers display unconsciously self-murderous behaviors, such as the continued drinking of a patient with esophageal varices and hepatic failure. This type of denial must be distinguished from other forms of denial, such as the "forgetting" of a brawny cardiac patient told not to shovel snow — a type of denial that evokes anxiety in the physician. Grossly self-destructive denial, on the other hand, stirs up malice. To make this distinction, it is important first to recognize that some patients — called "major deniers"[18] — deny without any self-destructive intent. They prize their independence and deny infirmity and chafe bitterly under the restrictions that a medical regimen imposes. But their denial is probably adaptive because they appear to survive longer than nondeniers.[18] The doctor working with a "major denier" should work cheerfully with the denial. Appeals to the patient's sense of sturdiness are harnessed to the necessary regimen. "Major deniers" tend to be likable and hard-working patients who respond to person-to-person medical advice delivered with a light touch and focused on maintenance of good health. Doomsaying, authoritarian approaches typically fail because the patient easily denies bad news.

The self-destructive denier is an entirely different story. Such patients are not independent and using the defense of denial in an attempt to survive. Rather, they are at base profoundly dependent and have given up hope of ever having needs met. Such patients seem to glory in their own destruction. They appear to find their main pleasure in furiously defeating the physician's attempts to preserve their lives. They may represent a chronic form of suicidal behavior; often they let themselves die.

A 45-year-old alcoholic man was familiarly called "Old George" by members of the emergency-ward staff. They had seen him a hundred times over six years for visits ranging from acute gastrointestinal bleeds to a subdural hematoma (after a fall that he barely survived). It became a standing joke that the more carefully Old George was tended and the more thoroughly he was worked up, the more furiously he drank. He was released from his hospitalization for the subdural hematoma on Monday, stitched up for multiple lacerations on Tuesday, allowed to "sleep it off" in the back hall on Wednesday, casted for a fractured arm on Thursday and admitted with wildly bleeding esophageal varices on Friday. The staff worked

frantically through the night, pumping in whole blood as fast as it would go, but at 4 a.m. the intern pronounced Old George dead, the junior resident muttered, "thank God," under his breath, and the senior resident said, "amen," quite audibly.

What the physician can do to help self-destructive deniers is quite limited. The starting point for the care of such a patient is to recognize without shame or self-blame that they provoke in their caregivers the fervent wish that they would die and "get it over with." Many physicians, recognizing in themselves such a wish, recoil — by temperament and by training. When the doctor encounters the expertly self-destructive patient, he or she is caught between the ideal of rescuing the patient on the one hand and the unwanted wish for the patient to die on the other. Depending on how mature the physician is about such hateful feelings, malice toward the patient will be either conscious and associated with little guilt or self-reproach[4] or hidden and a cause of feelings of dread, self-blame, gratuitously heroic rescue efforts or a flat, bland, given-up and hopeless attitude. The optimal care of the chronically self-murderous patient entails a psychiatric consultation for the patient to ascertain whether treatable depression exists. If the patient refuses such a consultation (and most do) the primary physician may have to fight the impulse to abandon the patient. It is crucial to recognize the limitations that such patients pose for even the most ideal caregivers and to work with diligence and compassion to preserve the denier as long as possible, just as one does with any other patient with a terminal illness.

Discussion

The "hateful patient," then, is the patient who — by a variety of behaviors related to profound dependency — stimulates a series of negative feelings in most doctors. Dependent *clingers* evoke aversion. Entitled *demanders* evoke fear and then counterattack upon entitlement. Manipulative *help-rejecters* evoke guilt and feelings of inadequacy. Self-destructive *deniers* (unlike "major deniers," who generally stir up affection mingled with anxiety) evoke all these negative feelings, as well as malice and, at times, the secret wish that the patient will "die and get it over with."

Day in and day out, however, the physician routinely helps most patients establish better contact with reality, better adaptation to painful illnesses and better relations with families, friends and other caregivers. What is it about the patient "everybody hates" that compromises these workaday skills? It is probably the additional burden of having to deny or disown the intense, hateful feelings kindled by the dependent, entitled, manipulative or self-destructive patient. What the behaviors of such patients teach over time is that it is not how one feels about them that is most important in their care. It is how one behaves toward them: the doctor who begins to feel aversion toward the patient should begin to think of setting limits on dependency. The doctor who begins to feel the impulse to counterattack should begin to think of rechanneling entitlement into expectations of realistically good medical care. The doctor who begins to feel depressed with the patient's smug help-rejecting should begin to think of "sharing pessimism" so that the patient's losing the symptom is not equated with losing the doctor. And the doctor who begins to wish that the patient would die should begin to grasp the possibility that the patient wishes to die.

Negative feelings about medical and surgical patients constitute important clinical data about the patient's psychology. When the patient creates in the doctor feelings that are disowned or denied, errors in diagnosis and treatment are more likely to occur. Disavowal of hateful feelings requires less effort than bearing them. But such disavowal wastes clinical data that may be helpful in treating the "hateful patient."

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