

The “Hateful Patient” Revisited: A Transactional View of Difficult Physician-Patient Relationships

June 19, 2015 | [CME](#) [1]

By [Greg Sazima, MD](#) [2]

How to frame a novel transactional model for attending to both patient and physician character styles and provide strategies for identifying and managing these interactions.

Premiere Date: June 20, 2015

Expiration Date: December 20, 2016

This activity offers CE credits for:

1. Physicians (CME)
2. Other

ACTIVITY GOAL

To frame a novel transactional model for attending to both patient and physician character styles and provide strategies for identifying and managing these interactions

LEARNING OBJECTIVES

At the end of this CE activity, participants should be able to:

1. Recognize that difficult patients often have lifelong struggles with their self-view that manifest in difficulty with interpersonal relationships, including the doctor-patient relationship
2. Define the complex doctor-patient interactions as well as how temperamental characteristics of both contribute to difficult interactions
3. Understand the particular characteristics of patient and physician archetypes and how they inform doctor-patient interactions

TARGET AUDIENCE

This continuing medical education activity is intended for psychiatrists, psychologists, primary care physicians, physician assistants, nurse practitioners, and other health care professionals who seek to improve their care for patients with mental health disorders.

CREDIT INFORMATION

CME Credit (Physicians): This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of CME Outfitters, LLC, and Psychiatric Times. CME Outfitters, LLC, is accredited by the ACCME to provide continuing medical education for physicians.

CME Outfitters designates this enduring material for a maximum of *1.5 AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Note to Nurse Practitioners and Physician Assistants: AANPCP and AAPA accept certificates of participation for educational activities certified for *1.5 AMA PRA Category 1 Credit™*.

DISCLOSURE DECLARATION

It is the policy of CME Outfitters, LLC, to ensure independence, balance, objectivity, and scientific rigor and integrity in all of their CME/CE activities. Faculty must disclose to the participants any relationships with commercial companies whose products or devices may be mentioned in faculty presentations, or with the commercial supporter of this CME/CE activity. CME Outfitters, LLC, has evaluated, identified, and attempted to resolve any potential conflicts of interest through a rigorous content validation procedure, use of evidence-based data/research, and a multidisciplinary peer-review process.

The following information is for participant information only. It is not assumed that these relationships will have a negative impact on the presentations.

Greg Sazima, MD, has no disclosures to report.

Cynthia Geppert, MD, MA, PhD, MPH, MSBE, DPS, FAPM (peer/content reviewer), has no disclosures to report.

Applicable *Psychiatric Times* staff and CME Outfitters staff have no disclosures to report.

UNLABELED USE DISCLOSURE

Faculty of this CME/CE activity may include discussion of products or devices that are not currently labeled for use by the FDA. The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational uses (any uses not approved by the FDA) of products or devices. CME Outfitters, LLC, and the faculty do not endorse the use of any product outside of the FDA-labeled indications. Medical professionals should not utilize the procedures, products, or diagnosis techniques discussed during this activity without evaluation of their patient for contraindications or dangers of use.

Questions about this activity?

Call us at 877.CME.PROS (877.263.7767)

It has been more than 35 years since James Groves, MD,¹ published his influential article, “[Taking Care of the Hateful Patient](#).” His powerful description of 4 archetypal patient styles that evoke dread in their caregivers has become standard reading in training programs in primary care medicine and in psychiatry. In developing a teaching conference series on the physician-patient relationship for residents in training, my colleagues and I built on Groves’ work. We framed a view of patient archetypes as well as of archetypal physician character styles, to advance a model of a transactional cycle between patient and physician, fueled by the personality dynamics of both. With an emphasis on cultivating a physician’s self-awareness in the moment-to-moment interaction with the patient, this model suggests tactics and practices that the physician can use with each of the difficult patient archetypes to make care more effective.

What is a “difficult” patient?

Groves identified 4 archetypal patterns of “hateful” patients (the less pejorative term “difficult” is used in this article). Relationships with these patients test the idealized image of the compassionate, intelligent healer whose goal is to cure or reduce the suffering of a compliant, appreciative patient. Instead, much of that image can get turned upside down: one can witness resentment of and acting out against the physician’s help and displacement of the patient’s conflicts of past and present personal life onto the clinical relationship. If unattended to, a counter-therapeutic manifestation of these circumstances can ripen and create shared helplessness, mutual hostility, and even abuse and abandonment—none of which meet the ideals of Hippocrates or Maimonides.

All archetypes operate with an unhealthy style of alliance or attachment to the physician. We can dust off valid concepts from the psychoanalytic work of Melanie Klein² to help identify these defensive behaviors via the concept of projective identification. Medical vulnerability is manifest as a self-critical distortion: “I’m sick” is equated with “I’m bad.” It is then broadcast behaviorally in the clinical setting with the treating physician as the target. The unconscious projection of that tension/judgment mix onto the physician serves a diagnostic purpose. The subsequent identifying with the now resonating physician completes the cycle—projection, then identification.

Commonly, this interaction is a replay of disruptions in attachment—the bond between the young child and parents/caregiver for basic security and soothing of suffering. This early challenge in bonding depends on consistency and reliability in the caregiver’s response to the child’s experience, and has been studied intensively by, among others, John Bowlby,³ Mary Ainsworth and colleagues,⁴ and Mary Main and Judith Solomon.⁵ As an additional line of association, we see how the milestone types of insecure attachment may well represent early drivers for subsequent interpersonal difficulties, particularly in the physician-patient relationship (**Table 1**). [Felitti and Anda’s](#)⁶ ongoing Adverse Child Experiences Study uncovered a clear association between disruptive early childhood experiences and subsequent rates of psychological suffering and poor physical health in later life (**Figure**).

CASE VIGNETTE

It is an early evening in 1978. The harried physician descends in the elevator from her primary care clinic office, irritable and depleted from her final clinical interaction of the day. Her last patient had peppered her with head-to-toe somatic worries. The doctor responded the way she always does, with a new fusillade of lab tests and consultation requests, the ordering of which pushes her workday way past sunset. As she exits the elevator to the strains of a Muzak version of “Stayin’ Alive,” missing the irony, the physician’s heart sinks as she sees the patient waiting for her by the lobby door, clutching her left forearm to her chest as if to keep it from falling off. “Oh, doctor, there was this one more thing you need to look at. . . . I think it’s cancer!”

Groves’ archetypes may also be defined via broadly researched personality constellations in psychiatric practice—including DSM. As with the DSM diagnostic schema, patients often do not fit cleanly into one archetype but may share the characteristics or styles of two or more archetypes.

Here are brief descriptions of these reframed archetypes.

Anxious/hypersensitive (“dependent clinger”)

This archetype aligns with elements of a DSM-informed anxious/hypersensitive personality type, driven by core, intense anxiety, deeply needy and requiring constant reassurance and attention. This type of patient tends to be dramatic, suggestible, and prone to somatic preoccupation and catastrophic thinking. Common behaviors include challenging and violating time and space boundaries (eg, visits that routinely run over scheduled appointment time, frequent “emergency” contact outside of office hours, insatiable requests for elaborate laboratory tests, or the latest medication for routine ailments).

Angry/narcissistic (“entitled demander”)

This archetype meets elements of the DSM narcissistic personality, driven by anger as the felt experience of narcissistic grievance and injury. This archetype poorly tolerates medical suffering, repressing/disavowing a sense of being “broken” but instead projecting it in hostility toward others who may only marginally trigger or deserve that intense, negative judgment. There is often an insistence on attention, control, and even humiliation through righteous demands for extra time, special consultation, and unnecessary tests. This type of patient is prone to verbal complaint, intimidation, and legal maneuvers.

Passive/aggressive (“manipulative help-rejecter”)

This archetype contains elements that are familiar to passive-aggressive personality types, binding the physician’s attention through “staying sick.” This type of patient professes a positive bond to the treater and treatment while passively compromising or even sabotaging appropriate treatment. The physician-patient relationship is a hedge against, and testing of, the deeper suffering of being abandoned—a deep, depressive position that is repressed but, again, gains life via covertly confounding treatment.

Borderline (“self-destructive denier”)

This archetype aligns with personality elements that clearly mirror the well-known borderline personality. The “denial” referred to is of the purported purpose of the medical transaction, instead using the “stage” of the doctor’s office to play out the wish of having one’s intense rage observed and understood. Groves describes this type of patient as displaying “unconsciously self-murderous behaviors,” not as some well-intended but poorly directed sense of regaining control but instead as a perverse, hostile way of expressing hopelessness. Such a patient is often barely in empathic contact with his or her psychiatrist, if only to express grievance through acting out in self-destructive ways with the physician as audience.

Physician archetypes: the other side of the transaction

While Groves emphasizes patient behaviors, patient archetypes do not behave in a vacuum but instead interact with their physician in a co-created cycle of experience and reciprocal behavior. Psychiatrists have their own unique psychological qualities that are often beneficial to self and society. Yet physicians nevertheless also exhibit their archetypal, unhealthy character attributes—the humble (and perhaps painful) “due diligence” identification that can help us better understand and manage the broader style.

Three such core physician archetypes are perfectionism, narcissism, and what can be termed “counter-dependency” or “false altruism.” As with patient archetypes, a physician may have a unique mix in type and intensity of the features mentioned.

Perfectionism

An outsized drive toward mastery is a familiar characteristic of individuals who enter the intellectually and affectively complex field of medicine. The cognitive abilities required for the profession self-select for those who are more highly motivated by a heightened, even compulsive need for perfectionism. These tendencies can also trend toward intolerance of or poor adaptability to the inevitable ambiguity and imperfection of the deeply human processes involved in health care, “difficult” patient or not. The threatened perfectionist may defend more actively with a hyperfixation on the “fix”—achieving a solution with a reflexive, mindless overemphasis on tests, procedures, and low-yield treatments.

Narcissism

An exaggerated desire to be thought well of is perhaps more difficult to own up to than perfectionism. This narcissistic style—a hypersensitive need to see oneself as worthy and even extraordinary—is classically considered a defense against an insecure sense of unconditional self-worth and inherent value. Ironically, the initial transaction is often unrealistically positive—the difficult/needy patient and “special” doctor collude on an idealized construction of the physician as different and better. That idealization inevitably gets challenged in the setting of a patient who does

not respond to treatment, reflects anger, or otherwise sabotages effective care. Narcissistic types may respond to this denting of the self in a more active way, via confrontation with the difficult patient or via a more passive response of retreat into inaction.

Counter-dependency ("false altruism")

This style manifests an ego-driven portrayal of selflessness in the service of patient care. The psychiatrist couches the need for specialness of purpose in a style that tends to engage the patient in a regressive way, often treating the patient in a condescending, child-like way, as a "victim of circumstance." Such a physician reflexively, mindlessly extends extra time and effort in professional service, with little awareness of imbalances generated in his personal life and threatening a healthy and more balanced direction of personal resources both within and outside the professional role. This style may also be described as false altruism to distinguish it from authentic altruism, a true opening in compassion to the patient's suffering. Psychoanalytic theory tells us that this false compassion represents an unconscious acting-over to suppress angry affects at being unfairly overburdened. Buddhist psychology has a blunter term for this state: "idiot compassion," suggesting a masquerading of the ego in the costume of caring.

CASE VIGNETTE

It is an early morning in 2015. The well-regarded and nattily dressed psychopharmacologist glides to his desk and, like a fighter pilot, begins his familiar multitasking: speakerphone speed-dialed to voicemail, laptop snapped open for a quick perusal of his daily schedule and e-mails. As he sips his half-soy double latte, he almost spills it as he reads an e-mail from a rather entitled, litigious patient who insists that he needs a flash-drive of his clinical record, which he will pick up later in the morning. The problem: the latest antidepressant trial did not work "fast enough." Angrily clicking through to his schedule, he finds the patient's next appointment and hits "delete."

Cycles of difficult interactions

Understanding characteristic temperamental tendencies in both patients and physicians helps us approach difficult patient archetypes not as static snapshots but rather as an interactive cycle fed by the personality dynamics of both parties. Each party contributes "baggage" to the trip that may ultimately perpetuate a mutually reinforced cycle of ineffective interaction. As seen in the **Figure**, each cycle has some emblematic features:

- A core patient vulnerability that tends to generate a predictable defensive reaction, which can be termed a "power move"
- A familiar experience, a "felt sense," in the physician that can generate or amplify vulnerabilities typical of that physician's archetypal mix of tendencies
- Contingent on that physician's level of awareness and alertness to the interaction and tendencies thereof, the physician's reactive behaviors may reinforce the dysfunctional cycle, as opposed to attending to the cycle to resolve it in order to achieve a more effective transaction

Letting the cycle run because of lack of awareness only gives it power and perpetuates it.

Understanding, anticipating, and cultivating a skill set to recognize specific interaction cycles—including the patient's and the physician's contributions—can lead to ways that the ineffective cycle can be resolved and consequently can lead to better outcomes. While every transaction is its own drama, there are some characteristic reactions and counter-reactions to look for (**Table 2**).

Anxious/hypersensitive cycle

The characteristic felt experience of a psychiatrist in the setting of the needy, anxious archetype tends toward a sense of depletion. A more self-aware analysis of the felt sense of **depletion** interprets it not as a personal intrusion but instead as a marker of patient anxiety and insecurity. If the sense of being depleted is poorly attuned to, it may manifest in some characteristic ways, all with the common theme of suppressing/avoiding other than attending to the affect generated. The perfectionist physician responds with further effort, harder work, and compulsive action on behalf of solving the puzzle but avoiding the underlying affects; ultimately, the physician disengages or burns. In this cycle, the narcissistic physician may feel it as an ego boost but inevitably will be let down because the patient's incessant neediness is not solved. And, the counter-dependent physician may respond with a regressive rushing-in with extra time in consultation or new and special treatment; he will later disengage using a contrived frame of "helpless" retreat.

When the psychiatrist finds himself in an anxious/hypersensitive cycle, it is essential that he model predictability and set boundaries. Firm expectations regarding appointment times and session duration must be shared with the patient. In addition, the patient needs to understand when and

how the psychiatrist will respond to non-emergencies outside of scheduled visits. A metaphor often used in our clinical teaching is of a “dose of doctor”—the interaction itself sometimes operating as an addictive substance for the anxious, needy patient, and best prescribed in a deliberate, structured, standard (rather than prn) regimen. Lastly, reframing care as collaboration, with the patient as a partner in the mission, challenges the undercurrent of the “needy child testing the parent” transaction. Self-monitoring diaries and coaching in healthy self-care (rest, nutrition, exercise, stress management tactics) can truly help in this regard.

Angry/narcissistic cycle

The angry narcissist, driven by poor tolerance of interior tension, shows an externalized, aggrieved reaction. In response, the gut-level reaction of the psychiatrist is that of being **attacked**. Opening to the experienced anger of the narcissistic patient can lead to understanding it as being, at least in part, a projected manifestation of the patient’s shame, borne of a sense of feeling imperfect or flawed. Each of the characteristic archetypal physician styles will have its own tendencies in managing that sense of attack, first via reflexive engagement, then by withdrawal.

The perfectionist physician responds to an attack with a familiar flurry of more action to fix the problem and avoid interacting with the vivid, angry affect generated. Because the patient’s angry, entitled style does not wane with the extra effort and may often, in fact, amplify as time and grievances over unresolved inner tension pile up, the perfectionist burns out.

The narcissistic physician working in combination with an angry narcissistic patient can be a combustible interaction, with a mutual need to be appreciated as extraordinary, resulting in a shared idealization doomed to mutual disappointment. The narcissistic physician may personalize the felt sense of being attacked as “ego injury” and mirror it back via confrontation with the patient. A well-intentioned setting/re-setting of boundaries around the demands of an angry patient may develop into a more sadistic withholding of appropriate treatment or a more passive maneuver, such as a delayed response to a patient’s call or to a patient’s request for a prescription refill.

The counter-dependent physician tends to respond to the push of threat, entitlement, and attack by reframing the work in a regressive way—“I can soothe this poor, angry creature” that avoids directly addressing the effect of apparent anger on the interaction. Such interventions may be perceived by the angry patient as further devaluation in the battle for power in the interaction and lead to more tension. With minimal returns on those efforts, passive retreat may ensue.

Being aware of one’s rising boiling point is essential, since a perceived attack is a trigger for the physician’s fight/flight reactivity. The patient’s frustration may be a valid manifestation of the physician’s shortcomings. In this case, a careful review of one’s actions and decisions is necessary and valuable in order to see what can be improved and what reasonable but unsuccessful interventions are being misinterpreted by the patient. Most of all, acknowledging the patient’s discontent—“you seem angry; if so, I want to understand that better”—is a fruitful approach and can be helpful in coaxing the latent tension into a verbalized rather than an acted-out state.

Many psychiatrists are reluctant to respond with empathy to a patient’s anger, fearing it will bring further attack or even represent an admission of guilt. A discussion of the patient’s suffering is more likely to make it safer for the narcissistic patient to gain a healthier view of treatment as a well-intended, at times imperfect, and almost always emotionally provocative experience. In those rare circumstances in which the patient’s unrelenting negativity and even threat bluntly interferes with the treatment process, early detection, acknowledgment, and documentation of the patient’s reactive behaviors can be of benefit during subsequent events, such as management of litigation and/or transfer of care to another physician.

Passive/aggressive cycle

The passive-aggressive patient acts out poorly tolerated interior states of tension via a passive sabotage of treatment. The typical felt-sense reaction of the physician to the dissonance between perceived alliance with the patient in face-to-face encounters and observation of countertherapeutic behaviors outside of the consulting room is one of **uncertainty**, of “what’s wrong with this picture?” Here again, each of the characteristic physician archetypes has its own style of reaction.

The perfectionist physician defends against feeling the covert hostility expressed in “defeated” attempts to help by avoiding the feeling generated and funneling that energy into a difficult intellectual task to be completed. As with the other interactions, this cycle can only run so long, then trend toward burnout and retreat. The passive-aggressive patient may well respond by “upping the ante” in terms of poor self-care in ways characterized as factitious behavior in DSM: self-destructive behavior without a clear secondary gain, but that nevertheless preserves the “dance” with the doctor.

The narcissistic physician is initially attracted to the passive-aggressive patient’s

presentation—reflecting the physician's own idealizing cravings and risking enmeshment in a symbiotic way with the sick-role interaction. Subsequent frustration from ongoing treatment failure can become amplified and personalized over time. Chronic unresponse to treatment can eventually lead to a rejection of the patient: covertly colluding with the patient's poor self-care by allowing the patient to be nonadherent to treatment without comment, or by bringing the hostility from a covert to an overt state with confrontation and rejection of the patient. The consequence of the latter may provoke a more overt self-destructive response from the patient, because it recapitulates a chaotic, ambivalent parental relationship likely experienced in early childhood.

The counter-dependent physician is faced with a kind of similarity with the passive-aggressive patient: both tend to suppress negative affects in service of a stable, if superficial, interaction and avoidance of overt conflict. The physician allies with only the positive surface identity of the patient as victim of circumstance; the patient covertly creates the conditions to stay sick and preserve the regressive cycle of interaction. The "I know what's right for you" physician style may mesh symbiotically with the patient's style for long periods while the ultimately necessary exposure of the patient's self-sabotage is avoided.

The physician's perception of uncertainty here is perhaps the subtlest of "difficult patient" reactions and a testament to the latent, often stable symbiosis that this particular interaction creates. With its recognition comes the challenge of broaching the pattern with the patient, who may be only minimally aware of his role in the ineffective interaction and threatened by bringing the psychological aspect into open discussion. Asking the patient, "Your treatment hasn't been all that successful; how do you feel about that?" can start to build a more reality-based alliance with a patient who one can reasonably speculate feels both uncertain and conflicted. Reality-testing the difficult state in an accepting way diminishes the fear that losing the symptom will result in losing the doctor. In re-engaging the alliance on a more realistic ground, negotiating (as opposed to dictating) explicit expectations and monitoring of the patient's adherence to treatment recommendations are essential.

Borderline cycle

The psychoanalytic term "borderline" historically refers to a border between neurotic and psychotic states. It is more clearly understood today as identifying the most unstable and primal of temperamental tendencies. According to Groves, borderline patients endeavor to "ruthlessly destroy the very care they crave." Like the passive/aggressive, the borderline archetype acts out interior tensions via sabotage of treatment but is much more overt in expressing and manifesting the intense rage and anxiety over perceived abandonment—commonly with roots in a chaotic, traumatic early life. The typical felt-sense reactions of the physician treating such a profoundly troubled individual are fluid and will often include characteristics of the other described archetypes (depletion, attack, uncertainty) and ultimately generate a **meta-reaction of disgust**—a clear projection of the patient's own radiating self-loathing.

This dynamic can manifest in the overall health care setting via "splitting" behaviors. In essence, the patient splits off intense mixed feelings toward the interaction by identifying one party in the interaction as "all good," and the other as "all bad." Unusual interpersonal tension among treating staff, especially in inpatient environments, is a reliable marker of borderline pathology. The borderline cycle brings out different reactions by each of the physician archetypes.

The perfectionist reacts to the chaotic, minimal alliance with the patient, and the disgust it generates, with familiar "fixing" defenses. Because the borderline patient is not driven to fix the problem but rather to use the relationship as a stage to reenact suffering, there is very little the perfectionist can "fix" to counter the understandable urge to exit the relationship. The patient in essence projects on the psychiatrist a sense that whatever the solution, it makes no difference. The narcissist may have an automatic, immediate reaction to the repulsive intensity of the interaction—a resonance with the patient's intense negative reactivity to the perceived self-centered style of the physician. While there may be moments of craved-for idealization feeding the narcissist physician in reaction to the borderline patient, their fleeting nature and tendency of borderline patients to morph into rebound rage ultimately repels the treater. Both temperamental styles operate in hypersensitivity and trading of aggression, even tending toward sadistic, mutual abuse in the relationship.

The counter-dependent physician manages intense disgust using a selfless, parental approach with limited expectations for the patient's role and self-control. Of the 3 physician archetypes, this type may be the best suited to coexist with the borderline patient. Yet the counter-dependent physician risks particular fallout from inattention to the repressed sense of hatred in the interaction. Losing empathy completely, but needing to couch that in condescending terms, this physician may allow

any and all wayward, self-destructive behavior without therapeutically confronting the obvious. This represents a therapeutic absence that often echoes an aspect of the borderline patient’s own early attachment difficulties.

Such clinical interactions often escalate with the patient testing the ability of the physician to tolerate increasing chaos in terms of suicidality, self-harm, and refusal to tend to medical illness. Such testing can also be seen as a form of sadism inflicted on the doctor—a projection of the patient’s own self-destruction—that needs to be forthrightly identified and confronted as a condition of ongoing treatment, with intensive, secure psychiatric treatment being a default response. A more mindful approach to the interactions with this most difficult type of patient begins with monitoring and even lowering one’s expectations for success. These are incredibly troubled human beings who manifest their suffering in a provocative fashion. Any expectation of smooth sailing is an unrealistic one; gains are best measured in terms of a gradual improvement in the frequency and severity of behavioral milestone events, such as fewer outbursts of acting out or self-harm. Besides managing physician expectations, it is similarly essential that patient expectations be clearly defined from the start. These include setting ground rules for scheduled visits (timeliness and duration), appropriate reasons/triggers for contact outside of scheduled appointments, and clear expectations of situations that might generate an emergency response from the physician. Finally, as with other patient archetypes, working to cultivate the verbalizing (rather than acting out) of tension and discontent is the broad goal in a mature physician-patient relationship. Routinely pointing out, without judgment, the reality of the patient’s out-of-control behaviors can be challenging but can provide an opening to a shared goal of working together to improve it.

Building better awareness

A necessary, even at times sufficient, antidote to breaking the cycles of difficult interactions is to cultivate an awareness of the interpersonal interaction as it occurs. While any physician can have the understandable tendency to flee or to minimize the intense emotional load that transfers from a difficult patient, cultivating a sense of being in the midst of a particular transaction and critically observing the outcome, can help identify and break the cycle. Without a developing awareness of the patient archetypes and the ability to identify how each of them makes us feel, physicians and patients are prone to inevitable cycling.

[Bateman and Fonagy](#)⁷ have written on the subject of psychiatric care of personality disorders—they use the term “mentalizing” to refer to the practice of attending to and conceptualizing mental states in oneself and others. This promotes a process of parallel, side-by-side attention that values shared understanding. States of tension are managed not by behavioral acting out, but instead by reflection, self-awareness, and verbal communication.

Physicians can help cultivate broader self-awareness in general and a mentalizing, felt sense in particular, by a range of practices and attitudes. First, we can reality-test and corroborate our subjective experiences by using peer/mentor support and mirroring. However exercised, some deliberate intention to process with trusted others both the “video” (witnessed narrative) and the “soundtrack” (somatic/emotional felt tone generated) of the physician-patient interaction can help correct distortions and helps reinforce developing awareness.

Mirroring the discrete structuring recommended for patient interactions, physicians can model their own expectations for professional and personal encounters. Such structure includes reasonable work hours, adequate rest, breaks, and an active personal life. These suggestions are admittedly obvious, yet they are remarkably poorly adhered to by many physicians.

Besides the support and corroboration of colleagues, cultivating one’s psychological/emotional self-awareness is often an interior affair. Mindfulness meditation is a well-regarded mode of training for this goal—not just in treating one’s own ambient tension, but more importantly in entraining the observation of one’s own mental processes in a gradually more subtle, granular way. Whether via basic sitting meditation or by mindful movement practices, awareness training sharpens one’s ability to tune in, in clarity, to the complex interaction and its effect on the individuals involved.

An effective physician-patient relationship includes awareness of the basic interpersonal interaction between two individuals—doctor and patient—each of whom has his own complex landscapes of mind. Particularly with difficult patients, awareness of both the patient’s temperament as well as your temperamental tendencies and in-the-moment feelings in clinical interactions helps inform healthier interactions and more effective care.

Acknowledgments—This CME activity was developed from research material presented at a colloquium conference series, “The Difficult Patient,” at the San Jose/O’Connor Family Medicine Residency Program, San Jose, Calif. I am grateful for the contributions of my Behavioral Science Faculty colleagues at the program: Katherine Mullins, MD, Frances Respicio, MSW, Robin Beresford,

RN, LMFT, PAC, and Michael Stevens, MD.

CME POST-TEST

Post-tests, credit request forms, and activity evaluations must be completed online at www.cmeoutfitters.com/PT (requires free account activation), and participants can print their certificate or statement of credit immediately (80% pass rate required). This Web site supports all browsers except Internet Explorer for Mac. For complete technical requirements and privacy policy, visit www.neurosciencecme.com/technical.asp.

PLEASE NOTE THAT THE POST-TEST IS AVAILABLE ONLINE ONLY ON THE 20TH OF THE MONTH OF ACTIVITY ISSUE AND FOR A YEAR AFTER.

Additional Reading

- Alexander GC, Humensky J, Guerrero C, et al. Physician narcissism, ego, threats, and confidence in the face of uncertainty. *J Appl Soc Psychol.* 2010;40:947-955.
- Allen JG, Fonagy P. *Handbook of Mentalization-Based Treatment.* Chichester, UK: John Wiley & Sons, Ltd; 2006.
- Balint M. *The Doctor, His Patient and the Illness.* 2nd ed. London: Pitman Medical; 1964.
- Banja JD. *Medical Errors and Medical Narcissism.* Sudbury, MA: Jones and Bartlett; 2005.
- Berne E. *Games People Play: The Basic Hand Book of Transactional Analysis.* New York: Ballantine Books; 1964.
- Gabbard G. *The Troubled Physician and the Perils of Perfectionism.* Grand Rounds, Menninger Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine; 2005.
- Groves JE. Borderline patients. In: Hackett TP, Cassem NH, eds. *The Massachusetts General Hospital Handbook of General Hospital Psychiatry.* 2nd ed. St Louis: CV Mosby Co; 1987:184-207.
- Hass LJ, Leiser JP, Magill MK, Sanyer ON. Management of the difficult patient. *Am Fam Phys.* 2005;72:2063-2068.
- Kabat-Zinn J. *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life.* 10th ed. New York: Hachette Books; 2005.
- Krasner MS, Epstein RM, Beckman H, et al. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA.* 2009;302:1284-1293.
- Krebs EE, Garrett JM, Konrad TR. The difficult doctor? Characteristics of physicians who report frustration with patients: an analysis of survey data. *BMC Health Serv Res.* 2006;6:128.
- Lipsenthal L. The physician personality: confronting our perfectionism and social isolation. *Holistic Primary Care.* Fall, 2005;6.

Figure. Association between disruptive early childhood experiences and psychopathology

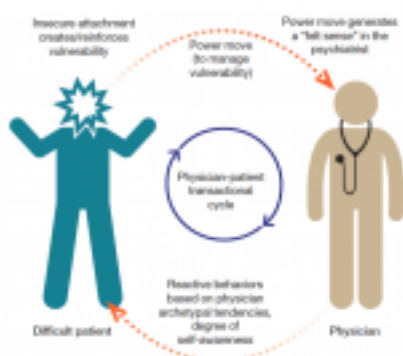


Figure. Association between disruptive early childhood experiences and...

Table 1 – Types of attachment¹¹

<p>Secure attachment:</p> <ul style="list-style-type: none"> • Child tolerates states of brief anxiety and returns to a steady state once mother returns. • Mother is responsive—child's needs are primary rather than her own.
<p>Insecure attachment: anxious/ambivalent/resistant type</p> <ul style="list-style-type: none"> • Child has a baseline anxiety, marked with the mother's absence and with extremes of reaction with mother's return. • The mothering style is rooted not in a receptive, child-centered approach but instead in one based on mother's self-centered (narcissistic) fears and needs. • The mix of intense yet opposite manifestations of the child's suffering, interior holding on to anxiety and an exterior pushing out of bad feeling as angry resistance, echoes what is witnessed later in the anxious/hyperactive and angry/narcissistic archetypes.
<p>Insecure attachment: avoidant/scoldant type</p> <ul style="list-style-type: none"> • Child has less of an observable connection to the mother. • Child manifests an emotionally limited, more quietly anxious "testing state," with little observable behavioral change with absence then return of the mother. • Mothers are observed as disengaged. • This style echoes the subsequent style of interaction noted in the passive/aggressive patient archetype: initial overt request for treatment but with eventual covert sabotage of treatment.
<p>Insecure attachment, disorganized/dissociated type</p> <ul style="list-style-type: none"> • Child presents with chaotic behavior: compulsive/waterproof rocking, hitting himself or herself, dissociating. • Child is barely or poorly soothed back into his prior steady state. • No real, effective connection to a caregiver. • This style echoes the deep, dysphoric primitivity that typifies the later borderline archetype.

Table 1 – Types of attachment

Table 2 - Physician-patient reactions and counter-reactions: approaches...

Disclosures:

Dr Sazima is Senior Behavioral Faculty, San Jose-O'Connor Family Medicine Residency Program, San Jose, Calif, and Affiliate in the department of family and community medicine at Stanford University School of Medicine, Stanford, Calif.

References:

1. Groves JE. Taking care of the hateful patient. *N Engl J Med.* 1978;298:883-887.
2. Klein M. Notes on some schizoid mechanisms. *Int J Psychoanal.* 1946;27(pt 3-4):99-110.
3. Bowlby J. *Attachment and Loss.* Vols 1 and 2. London: Hogarth Press; 1974.
4. Ainsworth MDS, Blehar MC, Waters E, Wall S. *Patterns of Attachment: A Psychological Study of the Strange Situation.* Hillsdale, NJ: Erlbaum; 1978.
5. Main M, Solomon J. Procedures for identifying infants as disorganized/disoriented during the Ainsworth strange situation. In: Greenberg MT, Cicchetti D, Cummings EM, eds. *Attachment During the Preschool Years: Theory, Research and Intervention.* Chicago: University of Chicago Press; 1990:121-160.
6. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. *Am J Prev Med.* 1998;14:245-258.
7. Bateman AW, Fonagy P. Mentalization-based treatment of BPD. *J Pers Disord.* 2004;18:36-51.

Source URL:

<http://www.psychiatrictimes.com/hateful-patient-revisited-transactional-view-difficult-physician-patient-relationships>

Links:

- [1] <http://www.psychiatrictimes.com/cme>
- [2] <http://www.psychiatrictimes.com/authors/greg-sazima-md>