Caring for Challenging Patients
Strategies to Keep You Going

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Groves’ thoughts have encouraged many clinicians and researchers since then to study the issue of challenging patients.

The hateful patient

In his article, Groves describes four types of “hateful” patients.

1. Dependent clingers
   • These patients have a bottomless need and perceive the physician as inexhaustible.
   • The clinician can experience a range of countertransferential feelings, including power, uniqueness, exhaustion and anger.
   • Today we may diagnose these patients with dependent personality disorder.
   • Physicians must set limits without rejecting the patient.

2. Entitled demanders
   • These patients resemble the clingers, but use intimidation, devaluation and guilt to get their needs met.
   • These patients are entitled and have narcissistic personality disorder.
   • The physician can feel fear, rage, shame, powerlessness or devalued, but must rechannel the entitlement in the direction of realistic care.

3. Manipulative help-rejecters
   • Appear to have a quenchless need for emotional support and also a belief that no regimen will help.
   • The physician will feel anxious, irritated, self-doubt, depression and guilt.
   • The patient’s symptoms are his or her admission ticket and the physician must be able to set limits on the relationship.
   • These patients may have borderline personality disorder.

4. Self-destructive deniers
   • These patients are profoundly dependent, but have given up all hope of ever having their needs met.
   • The physician may feel frustration, hopelessness or even a wish for the patient to die, but must fight the impulse to abandon the patient.
   • If there is no psychiatric comorbidity, these patients are best treated as one would a terminally ill patient.
The physician-patient encounter

Sledge suggests there are five components to the clinical encounter.5

1. Pre-encounter background

The pre-encounter background involves the physician and the patient, who both bring backgrounds of individual intrinsic factors, such as race, ethnicity, culture, sex and social class. The patient also brings a history of previous interactions with the medical system.

2. Pre-encounter anticipation

The patient and physician both have pre-encounter anticipations, such as fears, hopes and plans.

3. The setting

The setting of the encounter may involve available resources, time constraints and safety.

4. Reactions during the encounter

Both parties have reactions during the encounter. The patient’s symptoms can be seen as an initial offering, while the physician’s early response is critical to the outcome.

5. Consequences of the encounter

Lastly, both physician and patient will evaluate what happened and experience either satisfaction or frustration.

Finding solutions

Solutions begin with understanding the physician-patient relationship.

- We must understand and manage our countertransference.
- We must practise empathic, nonjudgmental listening, patience and tolerance.
- There must be a clear framework of time and content for interactions.
- Team discussions or rounds will enhance understanding and share responsibility.
- We must establish trust with our patients while maintaining a healthy distance.
- We must recognize all that the patient and physician bring to the encounter.
- Management of the problem involves witnessing, holding and effecting solutions.

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The heartsink patient

In 1988, O’Dowd coined the term “heartsink” patient.2 In his research, he found that a negative reaction to patients made the clinician feel unprofessional. The patients seemed to be dissatisfied with services while placing very heavy demands on the practice.

O’Dowd suggests clinicians have an average of six of these patients who are associated with two to three times higher rates of investigations and referrals. He also concludes that the clinician’s countertransference is key.

In his article, “The heartsink patient revisited,” Butler suggests heartsink patients are seeking salvation from their physician.3

Hahn describes the typical patient as someone with “three to four psychosomatic complaints and a mild to moderate depression, all embedded in a moderately abrasive personality.”4 He suggests it may be difficult or impossible to change the patient in any fundamental way and a more appropriate focus of intervention would be on the doctor-patient encounter and improvement in the therapeutic relationship.

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Several specific problematic patient diagnoses may benefit from further suggestions. Patients with a somatization disorder should be supported as necessary. Confrontation is rarely helpful. Regular office visits are important, as is limiting investigations, referral and emergency department visits.

For patients with a personality disorder, firstly “do no harm.” Try to reduce chaos in their lives. Use the clinic team to “dilute” the countertransference. Always screen for comorbid anxiety, depression and substance abuse. Treatment of the comorbid disorder can significantly reduce the difficulty of encounters with the patient. Use psychiatric consultation as necessary.

With any of these difficult patients, it may also be helpful to use the “stages of change” model developed by Prochaska and DiClemente. The stages include:

- precontemplation;
- contemplation;
- preparation and
determination, action and maintenance.

Understanding where the patient is on the continuum of change will help the physician understand how best to be a catalyst for change.

References