34 Communicating with "Difficult" Patients

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> “The attribution "difficult patient" reflects the physician's perspective. A patient, on the other hand, would likely speak of a "difficult doctor" (…) Together, they find themselves in a "challenging communicative situation.“
>
> Schwantes 2009: 155

Abstract: After an introduction to the issue of communicative interaction with “difficult” patients, four types of patients are distinguished and characterized: demanding dependent patients, invalidating patients, compulsively self-reliant patients as well as blameful aggressive and passive aggressive patients. Specific recommendations are given for the helpful approach to these types of patients, which are illustrated with examples.

34.1 Introduction: Relationship diagnosis and relationship design

No physician enjoys every patient interaction equally. Some patients are likeable and a pleasure to deal with; other patients one would rather avoid. In particular, patients who are very demanding, accusing or aggressive, patients who devalue the physician or insist on complete independence, and patients who cling helplessly to the physician are often experienced as difficult. It is often quite challenging to understand this behavior and to shape the medical consultation in a helpful way.

Many patients shape their relationship with their physician according to their relationship expectations and their internalized relationship map. Patients with an accentuated personality structure in particular do not react flexibly to a benevolent physician, but instead enact their personality problems in the medical consultation. They may treat the physician and other caregivers in a condescending manner, offer passive resistance, prove the physician's incompetence or demand the physician's constant presence. The physician is unconsciously forced into a certain role. As an idealized miracle worker, he is supposed to cure everything, take away the patients' suffering, free them from feelings of guilt and self-doubt, protect their self-esteem and autonomy, carry out non-indicated interventions or prescribe addictive drugs, etc. From the patients' perspective, this behavior corresponds to their "psycho-logic". From the physician's perspective, however, it is, at least initially, difficult to understand.

These situations are often challenging for physicians, who react with feelings of anger, powerlessness and distancing. It is a great advantage to be aware of own emotional reactions to typical interactions with the so-called 'difficult' patients, as these induced feelings can be used to understand the interactional behavior of the patient. If these emotional reactions go unnoticed, at least three consequences can result: Firstly, they cannot be used for relationship diagnostics. Secondly, they can lead the physician to act uncontrollably. Thirdly, they can result in diagnostic errors and medical decisions that are not beneficial to the patient, such as ordering unnecessary diagnostic or therapeutic procedures or omitting necessary clarifications.

The patients' interpersonal behavior and personality is shaped by early interpersonal interaction experiences. These are kept relatively stable through interactional feedback loops which developed in childhood interactions with important caregivers. In order to grow up well, a child

needs reassurance, love, guidance, protection, care, boundary setting, and respect for autonomy from its caregivers. In the course of development, the child identifies with their behavior and begins to behave in this way towards others. Behavioral expectations are formed and later passed on to others. For example, a person who was repeatedly invalidated as a child will later expect others not to value him or her as an adult.

Internally, a relationship map develops in which the internalized parental behavior is still very present. For example, if a person grows up with a lot of blaming and accusations in childhood, he or she will react very sensitively even to minor critical comments as an adult. Slightly critical remarks will be easily perceived as blaming and accusatory.

Conversely, these persons will also tend to develop a critical attitude towards others. While people with a more mature personality are able to react flexibly to everyday demands and shape their interactions, individuals with a personality disorder often react inflexibly and rigidly in interpersonal interactions. Their behavior tends to be either clingy or hostile and distant, with some individuals alternating between these attitudes. Mostly, these patients have markedly negative relationship expectations, i.e. they expect other persons to devalue them, despise them and behave abusively or neglectfully towards them.

Only an understanding of these latent relationship expectations makes it possible to master difficult interpersonal communication situations. Against this background, some typical ‘difficult’ interactions that frequently arise in practice will be described. Of course, it must be taken into account that both the physician and the patient shape the interaction and that the relationship problems are not exclusively caused by the patient's personality problems. It should also be considered that each patient must be viewed in their individual subjectivity. Nevertheless, there are some characteristic behaviors that will be described in the following sections with regard to demanding and dependent, invalidating, compulsively self-reliant, and aggressive patients.

34.2 The demanding and dependent patient

Almost every physician knows patients who openly demand sick leave, prescriptions, rehabilitation or pension without hesitation. Patients experience problematic life situations or their own failure as a chronic disadvantage that justifies compensation. The physician is supposed to grant this through his actions. Other patients turn to the physician in a

helpless, anxious, overly modest and clinging way. They present themselves as “good” patients who place their fate in the physician's hands and adapt themselves very diligently and submissively to the physician's instructions. Even if they behave helplessly and modestly on the surface, you can feel the patients' great desire for care and recognition in their interactions.

34.2.1 Understanding the behavior

Receiving something as a gift or being cared for is experienced by these patients as a sign of appreciation. These patients feel disregarded and unworthy if something is withheld from them (“I am not worthy of being given something”). These patients are not allowed to openly demand their wishes for care, as they have internalized that they will only receive care when they are weak and small, and will be rejected if they openly demand it.

The physician's counter-transference reactions can vary greatly. If these patients’ requests for care are openly demanded, feelings of anger and indignation will quickly arise. As the physician cannot fulfil their excessive demands for care, the patients will be easily disappointed. Not infrequently, they will consult another physician in order to obtain what they believe to be entitled to.

Helpless, overly modest or clinging patients tend to trigger a desire in many physicians to support them, help them and do something good for them. The patients’ behavior awakens impulses in the physician to care for and protect them like a child in need of care and support. The desire to be a good, understanding, empathetic and competent physician or therapist will quickly arise.

The patients’ behavior puts the physician in the role of someone who knows, guides and heals. However, after a certain time, the physician begins to feel uncomfortable, as the patients’ wishes take on an intensity that makes it difficult to respond to them. This type of physician-patient relationship is problematic because it reinforces the patients’ helplessness. Physicians then quickly feel compelled to distance themselves from their patients, with a tendency to send them away or dismiss them.

Typically, these patients were emotionally neglected and poorly cared for in their childhood. The patients’ central expectation of the relationship is not to be cared for and left alone. Against this background, patients openly demand care and support or try to present themselves in such a

way that the physician is willing to do a lot for them and to be highly committed to them.

34.2.2 Helpful approach to demanding and dependent patients

In the context of a supportive relationship, it is often necessary to allow a certain degree of dependency, especially if the patient is not able to reflect on this problem. It is then quite useful to consciously allow oneself to be used by a patient and to tolerate this kind of relationship without having to react in disappointment, e.g. by breaking off the relationship. At the same time, it is important to set clear boundaries. When talking to the patients, it is important to let them know that their desire for care is understood, but also to explain that there are limitations to fulfill these wishes (Wöller, Kruse 2020). Accepting the patients' wishes for a relationship means recognizing, respecting and understanding their need for a protective relationship with a strong and competent person against the background of biographical fears of being left alone.

Physician: "I can understand that you wish someone to be always there, because otherwise you might feel alone and lost without someone there to help you."

Some patients strictly adhere to their physician's instructions because they are convinced that they will not be liked, cared for or treated well if they present themselves as competent and with confidence. This concern can also be addressed directly.

Physician: "Perhaps you're convinced that I wouldn't really care about you if you appeared competent and confident."

It can also be beneficial to strengthen the patients' self-responsibility by rejecting their requests for advice. Instead, it is helpful to specifically strengthening their self-responsibility.

Physician: "I can see why you would want a physician who gives you a shot every day, but perhaps it will give you more if we try to understand what problem in your life is worrying you so that you can then find possible solutions to it." (Tress et al. 2004).

In order to strengthen the patients' personal responsibility, it is useful to clarify and support their autonomy wishes and to encourage them to make their own decisions. To do this, one can return the patients' questions about what to do and how to proceed to them. To this end, one can adopt an attitude of incompetence regarding what would be best for the patients, thus encouraging them to find their own answers. The physician's responsibility is supporting the patients in the search for their own solutions. He or she should strengthen their self-esteem by acknowledging their efforts and by trusting them to find a solution.

Physician: "What can you do to feel better?"

Interruption of treatment, e.g. due to longer vacations, or the end of treatment, can be a particularly critical phase for helplessly dependent patients, as fears of loss are very threatening for them. Therefore, interruptions or the end of treatment should be announced as early as possible.

Box 34.1 Helpful approach to demanding and dependent patients

- Recognize and control your own feelings in the counter-transference.
- Support the patients in a well-dosed form.
- Show understanding for the patients' wishes to be cared for and protected.
- Limit the patients' acting out of their dependency wishes.
- Strengthen the patients' personal responsibility and promote their independence.
- Reassure the patients of their competencies.
- Ask solution-oriented questions.
- Limit the patients in a constant relationship.

34.3 The invalidating patient

Some patients expect their physician to pay direct and unrestricted attention to them, to appreciate their special characteristics and uniqueness. If the physician is not "at their service", these patients react with anger, resentment, withdrawal, discontinuation of treatment and invalidation. These "narcissistic" patients often target the physician at his most vulnerable point. Sometimes these patients manage to unsettle the physician, they ask questions that the physician cannot answer, or provoke

answers that they later criticize as inaccurate. Some patients take satisfaction in proving to the physician that he is unable to recognize and treat their disease.

For the physician, such patients can trigger considerable feelings of anger, resentment, hurt and insult. A feeling of being exploited or not being seen in one's own professional efforts can arise in the physician. Some physicians also feel small and incapable in such situations and take on the role ascribed to them by the patients. Also, feelings of failure and professional incompetence can be induced, combined with feelings of shame and guilt.

However, patients with a narcissistic personality structure, can provoke different reactions in the physician. While some of them manage to evoke feelings of admiration, there are others who induce impulses to mock the patients because of their supposed greatness. In any case, the challenge is to perceive these impulses and not to act them out in the therapeutic relationship.

34.3.1 Understanding the behavior

We find invalidating tendencies particularly in patients with impaired self-esteem regulation. These occur in a very pronounced form in patients with narcissistic personality disorder. Patients with this disorder compensate for their own feelings of inferiority with exaggerated ideas of greatness, talent and importance. On the surface, they appear to be endowed with an unshakeable self-confidence that is often combined with arrogance, condescension and a lack of empathy. However, these patients are extremely dependent on the affirmation and admiration of those around them and are incredibly vulnerable. To compensate for their lack of self-esteem and to protect themselves from insults intense feelings of shame, they resort to their ideas of greatness. If they do not receive sufficient recognition and admiration, their damaged self-esteem becomes apparent, leading to what is known as narcissistic anger.

Narcissistic personalities need other people to stabilize their own self-esteem. Some manage to secure a constant flow of admiration and attention through their professional and private environment, thereby compensating for their low self-esteem. For others, however, the feeling of hurt predominates. They are forced to degrade other people in order to enhance their own self-esteem ("If other people are worth nothing, I can feel a little more valuable myself").

34.3.2 Helpful approach to invalidating patients

In order to make the interaction with narcissistic patients helpful, it is of key importance to be aware of one's own feelings in the counter-transference.

Particularly with patients who irritate their physicians with their arrogant and demanding nature, consideration should first be given to the extent to which these feelings are induced by the patient. This is particularly important if the physician has an objectively unfounded feeling of professional incompetence, but also if he or she feels particularly great, powerful, or superior.

In these relationships, it is helpful to realize that the patients are trying to compensate for deep self-contempt and shame through their grandiosity, arrogance and condescension, and that they have an intense desire for recognition and admiration.

If the patients idealize the physician, the latter can be tempted to indulge in the ideas of own greatness and act out rescue fantasies ("You are the only physician who has what it takes to really help me"). Typically, however, these efforts a doomed to fail, causing severe disappointment on both sides.

The aim of a helpful relationship is to distance oneself from the patient's narcissistic demands while at the same time maintaining a friendly and benevolent medical attitude.

If the physician experiences a deep sense of uncertainty and incompetence when interacting with a patient, it is advisable to check to what extent this feeling has arisen specifically in relation to this patient. If this is the case and the feeling of insecurity and incompetence does not arise when interacting with other patients, it is most likely a specific counter-transference reaction triggered by the patient's interaction style. It may then be helpful to assume that the patient has a deep feeling of inferiority and self-doubt which are fended off with the help of arrogance and fantasies of greatness.

Patients with a narcissistic personality disorder experience others only as an extension of themselves. Consequently, others merely lead a "satellite existence" for them, as they are not allowed to have their own needs and desires, but should only serve to regulate the patients' self-esteem.

The need to be recognized and admired in his greatness can also be understood from the fear of going unseen in the mass of people. When

relating to people with a narcissistic personality disorder, it is helpful to keep in mind the effort that it takes for the patient to constantly strive for admiration and attention. Furthermore, it is useful to empathize with the experience of shame, insult, humiliation and hurt in order to better understand the patients' self-depreciation. Often, for patients with a narcissistic disorder, it is humiliating to seek help from others, including a physician. It is hurtful for them to recognize that they have not been able to cope with life independently. Envy of the physician's competencies, social position or relationship skills can cause the patients to reject or dismiss much of what the physician advises and offers them.

To build a good physician-patient relationship, it is necessary to give the narcissistic patients the feeling of being seen, valued and respected. It is important to mirror and, if necessary, to admire them in an appropriate way for those aspects that can be authentically considered valuable.

It can also be helpful to mirror the patients' extremely high expectations and the necessary efforts they undertake. At the same time, it may be useful to kindly reject the high expectations these patients direct to the physician. It is equally important to empathetically understand the patients' high expectations in light of their biographical deficits and to limit these expectations in view of the realities of the therapeutic relationship.

Box 34.2	Helpful approach to invalidating patients

- Recognize and control your own feelings in the counter-transference.
- Understand invalidating behavior as a protection against feelings of unworthiness, shame and weakness.
- Maintain a benevolent relationship and convey feelings of appreciation and respect.
- Recognize effort and striving for superior performance as a way to self-regulate.
- Limit excessive narcissistic demands.

34.4 The compulsively self-reliant patient

In the relationship with their physician, patients who are compulsively self-reliant tend to present themselves as independent, strong and self-

confident. They do not want to give the impression of being dependent on other people and tend to present themselves as healthier than they are. As a result, they deny and trivialize their complaints, even in threatening medical situations, such as heart or asthma attacks. Their denying of any fear can lead to a significant delay in seeking medical help.

Compulsively self-reliant patients want to make it on their own in any case and often give heroic accounts of how they have exposed themselves to danger but also saved themselves. Hospital stays in particular and the associated dependencies are to be avoided at all costs. If they are hospitalized, they insist on being discharged quickly. The physician-patient relationship can prove challenging for two reasons. Firstly, these patients deny their complaints and often visit their physician at the very last possible moment. Secondly, these patients are often skeptical about medical recommendations and tend to discontinue medication independently and change the dosage on their own which leads to problems with therapy compliance.

This type of behavior often causes anger on the part of the physician. The physician feels that he or she is not being taken seriously, is offended and annoyed by the patients' inappropriate behavior. Sometimes, physicians exert pressure on patients to comply with their instruction and appeal to their obligation to maintain their health. This can lead to a real power struggle, with both physician and patient trying to prove that they are right.

34.4.1 Understanding the behavior

Patients behave in such an overly autonomous manner because they are basically not really independent. They are very vulnerable and build up a hard shell to hide their vulnerability. Their wishes for attention, care and closeness are also fended off by this behavior, as they are worried that they will only receive attention and closeness if they give up their independence. Hospital stays threaten the patient's independence while unconsciously mobilizing their desire for attention, care and closeness. Due to the conflicting nature of these desires, they take excessive measures to preserve their independence.

34.4.2 Helpful approach to compulsively self-reliant patients

When interacting with compulsively self-reliant patients, it is very helpful to bear in mind that they do not primarily want to upset the physician, but rather secure their autonomy, which they perceive as being under threat. The patient acts out of an exaggerated fear of losing their independence and self-esteem.

It is of utmost importance to respect the independency and autonomy of these patients within the physician-patient interaction. This is why it is also advisable to include the patient in therapy decisions. Especially when it comes to perceived fear on the patient's side regarding the matter of independence, it is necessary for the patient to feel that it is their own independent decision to start therapy. Therefore, patients should have the possibility to choose, and therapeutic alternatives should be provided.

If these patients develop the feeling of being pressured, they will start to resist openly or covered. This can manifest itself in therapy either as an open rejection of what the physician recommends or as a secret opposition with the patient failing to adhere adequately to the treatment regimen. It is important to understand that the patients protect themselves from the physician in this way in order to preserve their own independency. Sometimes, they will start telling lying to the physician instead of opening up. As a result of incorrect information provided by patients, the physician may increase the dosage of medication or change the prescription in order to compensate for the absence of therapeutic success, although the primary reason for the lack of success is the patient's refusal to take the drug.

In this context, it might be helpful to address the patients' fear of dependence in specific situations, to take this fear seriously and to develop solutions together with them.

> Physician: "Let us think about ways to make your stay in hospital easier."

Box 34.3 Helpful approach to compulsively self-reliant patients

- Understand the patients' insistence on independence with regard to their vulnerability and fear of dependence.
- Notice own feelings of counter-transference, e.g. your tendency to distance yourself internally from the patients.
- Make treatment decisions together with the patients and, wherever possible, give them the freedom to make their own decisions.
- Address the patients' fears of dependency and their search for solutions.

34.5 The blameful aggressive and passive aggressive patient

Some patients tend to challenge the physician-patient relationship by being aggressive or making accusations. Of course, a patient should be able to be angry with his or her physician and address this if necessary.

However, the physician-patient relationship can be jeopardized through continued aggressive and accusatory behavior on the patient's side. Other patients are not confrontationally aggressive, but show their aggressive tendencies indirectly. Superficially, they seem friendly, well adapted and agreeable. On the other hand, they might be skeptical when they are given suggestions on how to change their behavior and may even reject them. No therapeutic measures seem to help, even though the physician tries their hardest. Feelings of helplessness and not doing enough can arise. Some of these patients are openly reproachful and accusatory, while others seem to make a silent reproach. Every statement is met with rejection and irritability.

Other patients show their protest by highlighting the side effects of pharmacotherapy, almost with a subtle sense of triumph. The medication, and also the prescribing physician, are experienced as harmful. On the physician's part, this can trigger feelings of guilt, as well as feelings of having failed or not having done enough for the patient. Alternatively, the physician may be tempted to make counter-accusations, for example by saying, "You are not really cooperating", or feel the impulse to justify himself or herself. Sometimes, these patients might be advised to switch

physicians. Many physicians find it difficult to accept being forced into a role in which they are perceived as “perpetrators” who intentionally harm their patients with the side effects of medication.

34.5.1 Understanding the behavior

Patients who tend to be accusatory and dismissive have no conscious access to these behaviors. They are not intentionally defiant, nor do they deliberately aim to provoke feelings of guilt. Often, this behavior is based on the actualization of an early object relationship. Some patients may reject the physician’s interventions because they experience them as hostile due to a negative transference projected to the physician.

Most of these patients had early childhood experiences where contradiction was not tolerated, and open confrontation was not allowed. Aggressive behavior was met with separation, emotional withdrawal, revenge, incomprehension, and disinterest. Therefore, these patients may hardly notice the physician’s efforts but instead feel that the physician is behaving like their early caregivers who were not truly interested in them.

The patients remain convinced that the physician simply does his or her job without actually caring about their patients. At the same time, the patients hold on to the hope of eventually gaining the physician’s interest, attention, and care. They tend to adapt to the physician for fear of being dismissed, still in hopes to be noticed. Evoking guilt, showing passive resistance, and covert refusal serve unconsciously to attract the physician’s attention and interest while simultaneously preserving autonomy.

34.5.2 Helpful approach to aggressive patients

When dealing with openly aggressive and passive aggressive patients, it is first important to clarify one's own counter-transference feelings and impulses. On one hand, it is necessary to internally distance oneself from the feelings of guilt induced by the patient. On the other hand, there is a risk of making accusations, expressing annoyance, trying to control the patient, distancing oneself, or breaking off contact. Regardless of how justified you consider the patients’ feelings and how you explain their origin, it is advisable to first acknowledge and mirror the feelings of the patient.

> Physician: “Is there something that is making you really angry?”
>
> Physician: “I have the impression that you were somewhat disappointed by my reaction?”
>
> Physician: “Do you think I should not have prescribed this medication?”

The next step should be to clarify the reason for the anger, dissatisfaction, disappointment, or accusations. If the physician has indeed made a mistake, this possibility should be acknowledged without extensive justification. For some patients, it is already a major step forward to be able to express disappointment and anger toward the physician without fearing that the physician will stop caring for them.

If the physician senses that a patient is unconsciously re-actualizing the relationship with earlier caregivers within the physician-patient relationship, it is recommended to address this early and to offer the patient a realistic perspective on the possibilities and limits of collaboration between an adult patient and a physician. In cases of persisting aggressive behavior, it can be helpful to point out the limits of the physician’s ability under such circumstances.

> Physician: “I cannot work well, when you treat me this aggressively. How should we address this?” (Wöller, Kruse 2020: 361, modified from Kernberg 1993: 35)

Instead of entering in a power struggle with the patient, it might be advisable to temporarily take the subordinate position.

> Physician: “I think it would be easy for you to prove to me that therapy is not helping. Currently, I myself am also seeing few possibilities how therapy could be helpful for you. But maybe you have an insight on how effective help might be realized for you?” (Wöller, Kruse 2020: 361)

Box 34.4 Helpful approach to aggressive patients

- Accept the patients' aggressive feelings and implicit or explicit accusations and clarify their underlying causes.
- Notice your own impulses of counter-transference.
- Distance yourself internally from self-directed accusations, particularly from feelings of guilt and failure.
- Acknowledge any actual mistakes or shortcomings and point out your own limitations.
- Support the patients empathetically while setting boundaries in the event of aggressive behavior.
- Involve patients in shared responsibility for the therapy's success.

34.6 Further information

A number of other patient groups and situations can be experienced as particularly challenging by physicians. For example, patients with chronic pain or somatoform disorders can induce strong feelings of helplessness in the physician, especially when they make intense demands for help while simultaneously showing the tendency for somatization (§ 32, 33).

It is necessary to adapt communication strategies to these patient groups in order to develop a strong physician-patient relationship (§ 3, 17, 32). This applies not only to medical consultations, but also to psychotherapeutic treatments where the communication challenges described above need also consideration. Further information on this can be found in the relevant literature (Wöller, Kruse 2020).

References

Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

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