The Difficult Patient and the VIP

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Keeping your cool

while the world

around you bursts

into flames

Disclosure:

Philip R. Muskin, MD, MA, DLFAPA

With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between me (and/or my spouse) and any for-profit company in the past 24 months which could be considered a conflict of interest.

Goal(s) of This Talk

Learn to identify different types of difficult patients

Learn how to manage difficult patients in a way that facilitates adherence to medical care

Learn how to maintain your professionalism while dealing with difficult patients and situations (not wanting to punch everyone in the nose)

- **Respect for Persons/Autonomy**

Acknowledge a person's right to make choices, to hold views, and to take actions based on personal values and beliefs.

- **Justice**

Treat others equitably, distribute benefits/burdens fairly.

- **Nonmaleficence (do no harm)**

Obligation not to inflict harm intentionally; In medical ethics, the physician's guiding maxim is "First, do no harm."

- **Beneficence (do good)**

Provide benefits to persons and contribute to their welfare. Refers to an action done for the benefit of others.

What is a *difficult* patient?

1. I know one when I see/experience one
2. **VIPs** - Often the most difficult of patient situations
3. Patients with severe personality types/disorders
4. Patients who are uncooperative
5. Patients who are seductive (power, money, sex)

   In that order, let's be honest

6. Patients who threaten
   - Physically
   - Administratively
     - "I'm calling the chair, hospital president, my famous relative, etc. "; **see #2**)
   - Litigation

How to spot a patient with a personality problem

- Some staff find the patient difficult, others do not.
- ALL staff find the patient difficult, you do not.
- History confirms that the patient had difficulties with other people or during hospitalizations (by chart or by rumor).
- The problems are not directly caused by:
  - Depression/Mania, Psychosis
  - Drug use
  - Medications
  - Obvious medical causes: delirium, dementia, seizures, stroke

Personality problems interfere with inpatient care

- Refuse interventions
- Elope
- Leave AMA (with much frustration on the part of everyone)
- **Refuse** to leave (even worse)
- Threaten or attempt suicide
- Get violent, agitated, or threaten to harm staff
- Violate rights of staff/other patients
- Complain to hospital administration and threaten lawsuits
- Cause staff to feel aroused, angry, guilty, humiliated, inadequate, sadistic, vengeful (and many more uncomfortable emotions)

Borderlines

Patients with borderline personality disorder have very unstable internal states

They have many shifting personality styles

In one day a patient with borderline personality may behave masochistically - then sadistically; be paranoid/rejecting - then be dependent; be self-deprecating - and finish off narcissistically.

Behaviors suggestive of Borderline Personality Disorder

Cutting	**Suicidal behaviors**	**Brief episodes of paranoia**
Easily angered	**Feelings of emptiness**	**Splitting**
Impulsive	**Unstable self-image**	**Fears of abandonment**

Personality Styles

1. Paranoid
2. Antisocial

ANTAGONISTIC due to intense distrust

3. Dependent
4. Masochistic
5. Histrionic

NEEDY due to intense desire for emotional caretaking

6. Narcissistic

HAUGHTY due to intense feelings of inferiority

Paranoid personality disorder
SUSPECT[9]
Spousal infidelity suspected
Unforgiving (bears grudges)
Suspicious
Perceives attacks (and reacts quickly)
Enemy or friend? (suspects associates and friends)
Confiding in others is feared
Threats perceived in benign events

Schizotypal personality disorder
ME PECULIAR[9]
Magical thinking
Experiences unusual perceptions
Paranoid ideation
Eccentric behavior or appearance
Constricted or inappropriate affect
Unusual thinking or speech
Lacks close friends
Ideas of reference
Anxiety in social situations
Rule out psychotic or pervasive developmental disorders

Borderline personality disorder
IMPULSIVE[10]
Impulsive
Moodiness
Paranoia or dissociation under stress
Unstable self-image
Labile intense relationships
Suicidal gestures
Inappropriate anger
Vulnerability to abandonment
Emptiness (feelings of)

Schizoid personality disorder
DISTANT[9]
Detached or flattened affect
Indifferent to criticism or praise
Sexual experiences of little interest
Tasks done solitarily
Absence of close friends
Neither desires nor enjoys close relationships
Takes pleasure in few activities

Antisocial personality disorder
CORRUPT[9]
Cannot conform to law
Obligations ignored
Reckless disregard for safety
Remorseless
Underhanded (deceitful)
Planning insufficient (impulsive)
Temper (irritable and aggressive)

Borderline personality disorder
DESPAIRER*
Disturbance of identity
Emotionally labile
Suicidal behavior
Paranoia or dissociation
Abandonment (fear of)
Impulsive
Relationships unstable
Emptiness (feelings of)
Rage (inappropriate)

* Created by Jason P. Caplan, MD

Histrionic personality disorder
PRAISE ME[9]

Provocative or seductive behavior
Relationships considered more intimate than they are
Attention (need to be the center of)
Influenced easily
Style of speech (impressionistic, lacking detail)
Emotions (rapidly shifting, shallow)
Make up (physical appearance used to draw attention to self)
Emotions exaggerated

Narcissistic personality disorder
GRANDIOSE[11]

Grandiose
Requires attention
Arrogant
Need to be special
Dreams of success and power
Interpersonally exploitative
Others (unable to recognize feelings/needs of)
Sense of entitlement
Envious

Dependent personality disorder
RELIANCE[9]

Reassurance required
Expressing disagreement difficult
Life responsibilities assumed by others
Initiating projects difficult
Alone (feels helpless and uncomfortable when alone)
Nurturance (goes to excessive lengths to obtain)
Companionship sought urgently when a relationship ends
Exaggerated fears of being left to care for self

Histrionic personality disorder
ACTRESSS*

Appearance focused
Center of attention
Theatrical
Relationships (believed to be more intimate than they are)
Easily influenced
Seductive behavior
Shallow emotions
Speech (impressionistic and vague)

* Created by Jason P. Caplan, MD

Avoidant personality disorder
CRINGES[9]

Criticism or rejection preoccupies thoughts in social situations
Restraint in relationships due to fear of shame
Inhibited in new relationships
Needs to be sure of being liked before engaging socially
Gets around occupational activities with need for interpersonal contact
Embarrassment prevents new activity or taking risks
Self viewed as unappealing or inferior

Obsessive-compulsive personality disorder
SCRIMPER*

Stubborn
Cannot discard worthless objects
Rule obsessed
Inflexible
Miserly
Perfectionistic
Excludes leisure due to devotion to work
Reluctant to delegate to others

* Created by Jason P. Caplan, MD

ANTAGONISTIC: *Paranoid*

Grew up with this mindset:

"People want to take advantage of me."

"I have to suspect everyone and guard against mistreatment."

Paranoid patients will misinterpret the normal inpatient routine and think staff is concealing information, lying, or otherwise trying to misuse them.

Paranoid patients will suspiciously refuse treatment and bitterly complain about the staff's intentions.

Paranoid patients can get quite angry, menacing, or even violent in response to perceived wrongs.

Paranoid patients violate our desire to be seen as benevolent, making us discouraged and angry.

Needy: Dependent

- Grew up with this mindset:
  - "I won't get the emotional caretaking I need unless I cling onto people for dear life."
  - "If they're not giving me the care I need, I need to act like a disappointed child to convince them to take care of me."
- They are clingy and require constant reassurance:
  - Use call button way too much.
  - Won't let staff leave the room (you too)
  - If they are not getting what they want they act disappointed and anxious to guilt/shame staff into taking care of them.
- Will sabotage treatment if they think it will bring more staff attention
- Their physicians may initially be compassionate, but eventually will become annoyed.

Needy: Histrionic

- **Grew up with this mindset:**
  - **"I won't get cared for unless I'm sexy, admired, and the center of attention."**
  - **"If I'm not getting the caretaking I need, I must be more charming, dramatic, lively, masculine/feminine"**
- **These patients are dramatic about most everything.**
- **They try to be the super-woman or super-man and be appealing, interesting, or overtly flirt with staff.**
- **They will try to remain sexy and in the spotlight, even if it means sabotaging treatment or denying their illness.**
- **They will be hurt if the physician does not seem taken with them and they will then sulk and reject treatment.**
- **Their dramatic style can be charming at first, but generally ends up being annoying.**

Needy: Masochistic

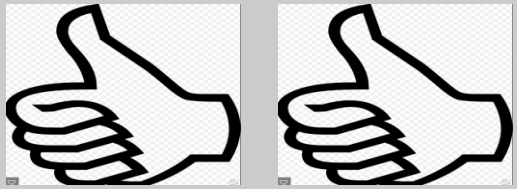
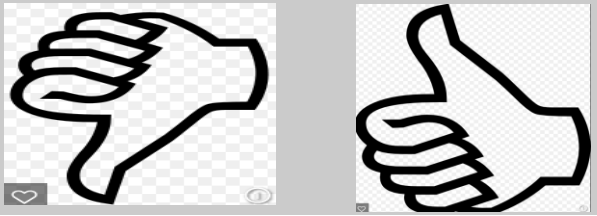
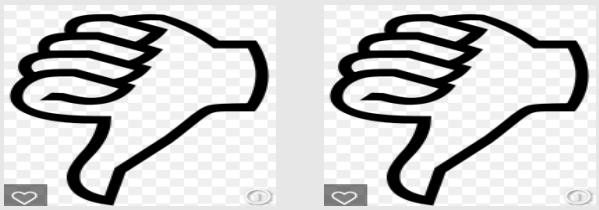
- **Grew up with this mindset:**
  - **"I won't get the emotional caretaking I need unless I show that I am suffering."**
  - **"I bear things with more forbearance than others"**
- **Hospitalization is gratifying because it means the patient is suffering (this is NOT conscious).**
- **Getting better is terrifying because it means that emotional care may be withdrawn (this is NOT conscious).**
- **Complain loudly, but seem to reject every attempt at help.**
- **Sometimes seem to enjoy torturing others with their suffering (this is NOT conscious).**
- **Physicians response: the cycle of sado-masochism**
  - **Tend to work harder in response to the complaining.**
  - **Get annoyed when the patient rejects their interventions**
  - **Feel angry and vengeful towards the patient (sadism)**

Narcissistic

- Narcissists suffer from an unconscious inferiority complex -- deep down, they feel inadequate *(But it does not feel this way*)
- Narcissists fight desperately to keep the inferiority unconscious by convincing themselves that they are special, the best, deserving, and entitled
- Narcissists idealize “special” staff members and haughtily devalue the others.
- Narcissists seem self-absorbed and lack empathy for others
- With a narcissist, the slightest disrespect triggers shame, leading to anger (narcissistic injury)

- From staff’s perspective, being idealized can feel good, but being devalued can make one furious, vengeful, or avoidant of the narcissist.

Quick Guide to Attachment Styles

ME (+)	ME (-)
Secure I'm OK. You're OK. 	**Fearful/Preoccupied** I'm **not** OK. You're OK.. 
Dismissive I'm OK. You're **not** OK. 	**Disorganized** Neither of us is OK. 

Insecure Attachment Styles -1

- Patients with **dismissing** attachment relationships appear to be intensely self-reliant stemming from consistent emotional rejection or unavailability by caregivers. They downplay the importance of the medical problem, and appear to have little need for others when distressed. Their negative emotions, such as anger, are not directly expressed and other people, including their physicians, may experience them as invulnerable.

Insecure Attachment Styles - 2

- Patients with a **fearful/preoccupied** attachment style seem to always be seeking care. They seem to exaggerate physical symptoms of illness in the hope of getting more from their doctors. Patients who are preoccupied in their attachment relationships often appear as dependent and overly needy. They seem to have little or no self-confidence, and do not trust their own judgment when dealing with problems of even a trivial nature. Physicians often feel angry with such patients who are experienced as overwhelming in their care-seeking behavior.

Insecure Attachment Styles - 3

- Patients who have a **disorganized** attachment style are simultaneously help-seeking *and* help-rejecting, stemming from their inability to trust themselves or their caregivers. They typically have a history of abuse by significant figures. They can be demanding of medical attention while being non-adherent to recommendations. This style can result in physician burnout and highly negative feelings towards the patient. Their physicians often feel incompetent when dealing with the patients as well as feeling frustrated.

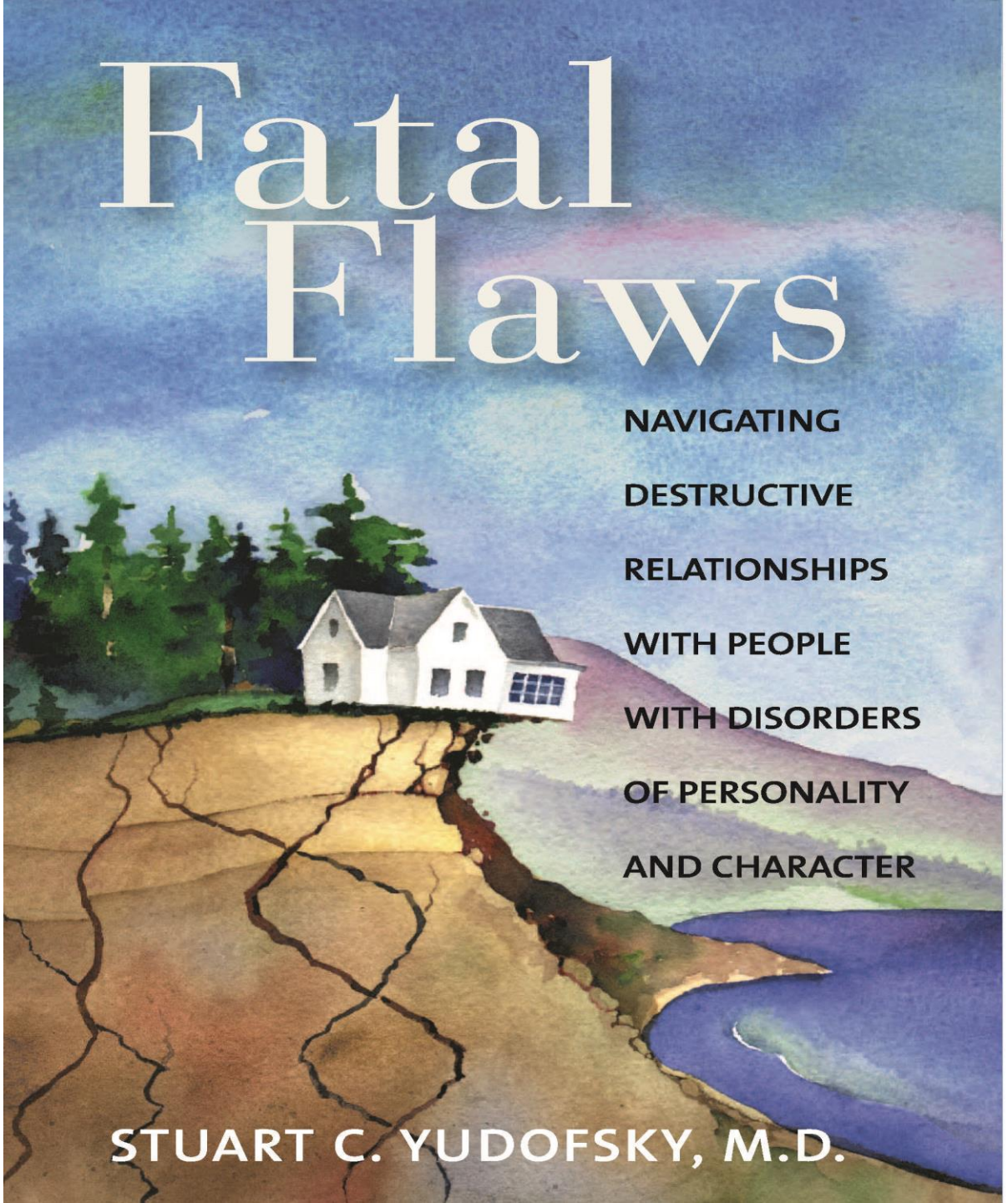
Table 2 – Physician-patient reactions and counter-reactions: approaches to breaking the cycles of difficult interactions

Archetype	Vulnerability	Power move	MD "felt sense"	MD reaction	MD approach
Anxious/hypersensitive "dependent clinger"	Feel bad = am bad	Neediness, more attention, breaking boundaries	Depleted, exhausted by patient's needs	P: "I'll figure it out, I just need to work harder" N: "He needs me" C: "The poor thing"	P: "This makes you anxious—I understand" N: Set boundaries C: Dose of MD[a]
Angry/narcissistic "entitled demander"	Feel bad = who's to blame?	Threats, criticism, entitlement	Attacked	P: Frozen (hard to work when attacked) N: "No, how dare you?" C: "I can soothe the beast"	P: "This makes you anxious—I understand" N: Watch own reaction C: Be thorough
Passive/aggressive "manipulative help-rejecter"	Intolerable anger: buried, covert	Needy but sabotages treatment	Uncertain: "what's wrong with this picture?"	P: Endless tests N: Mixed (sick role feels good, but treatment failure does not) C: Allies with "poor thing," stuffs the disgust	P: "This must be difficult for you" N: "Here's how we need to work together" (set explicit expectations)
Borderline "self-destructive denier"	Rage over abandonment: quite overt	Overt self-destructive behavior, minimal treatment adherence	All of the above + disgust	P: "Doesn't matter if I figure this out" N: I don't want this" C: "I wish him well, but . . ."	P: "This all feels out of control, you agree?" N: Manage (lower?) your expectations C: Set basic expectations for behavior

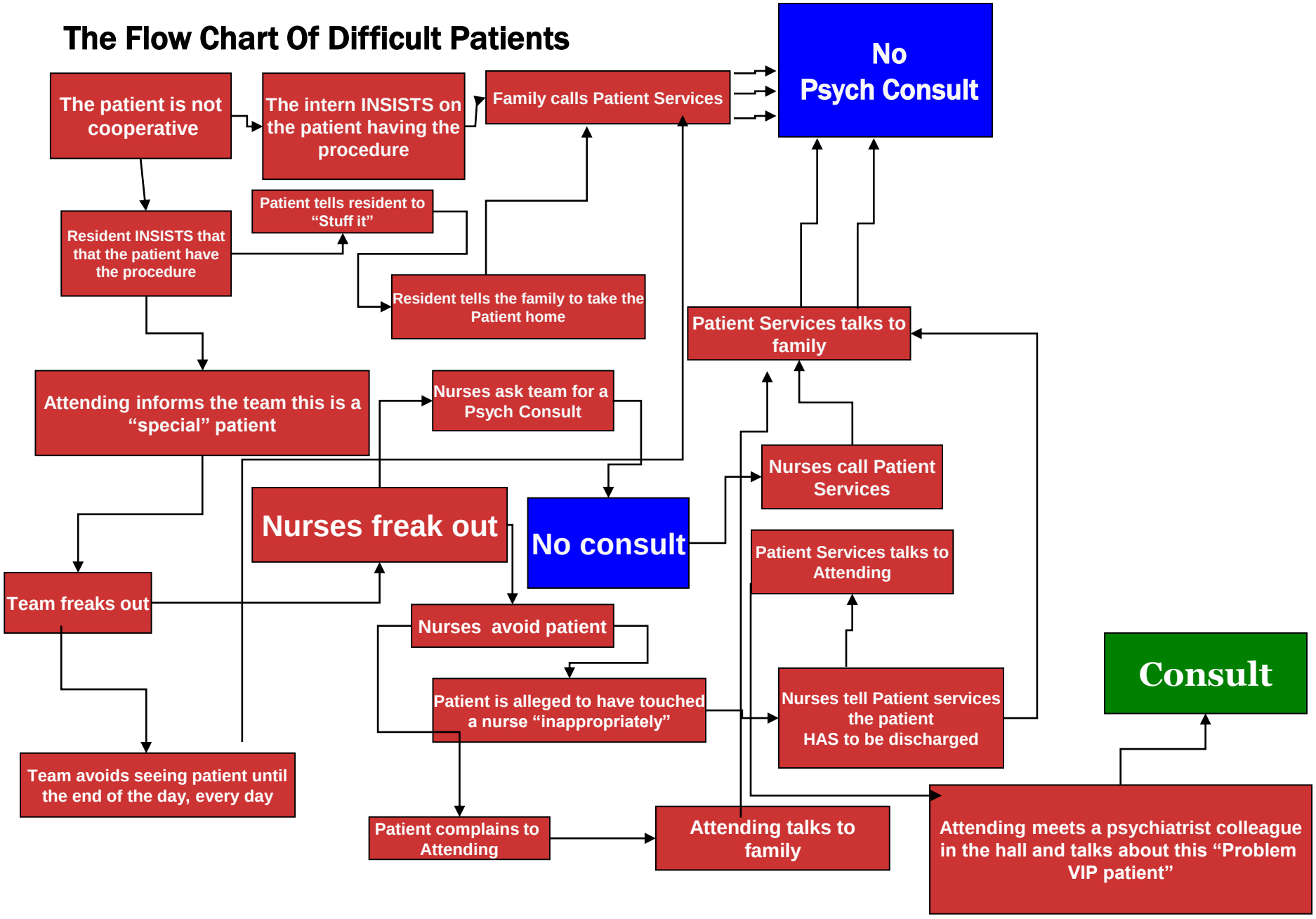
P, perfectionist; N, narcissistic; C, counter-dependent.

[a] Direct interaction "prescribed" in a deliberate, structured, standard (rather than prn) regimen.

Sazima G: The "Hateful Patient" Revisited, Psychiatric Times June 2015


Fatal Flaws
NAVIGATING DESTRUCTIVE RELATIONSHIPS WITH PEOPLE WITH DISORDERS OF PERSONALITY AND CHARACTER
STUART C. YUDOFSKY, M.D.

The Flow Chart Of Difficult Patients



The Role of Compulsiveness in the Normal Physician

Glen O. Gabbard, MD

• **This article presents some observations from a workshop setting about the role of compulsiveness in the normal physician. Case examples illustrate the effect of this character trait on the professional, personal, and family life of the typical physician. Doubt, guilt feelings, and an exaggerated sense of responsibility form a compulsive triad in the personality of the physician. This triad manifests itself in both adaptive and maladaptive ways. This article focuses primarily on the maladaptive, including difficulty in relaxing, reluctance to take vacations from work, problems in allocating time to family, an inappropriate and excessive sense of responsibility for things beyond one's control, chronic feelings of "not doing enough," difficulty setting limits, hypertrophied guilt feelings that interfere with the healthy pursuit of pleasure, and the confusion of selfishness with healthy self-interest.**

(*JAMA* 1985;254:2926-2929)

Finding the solution

Algorithmic Solutions

Heuristic Solutions

Finding the solution

Algorithmic Solutions

- Agitation = 5 2 & 1
  - No attempt to understand the agitation
- > ELOS = Must discharge
- "Hospital policy" ***This*** is not permitted
- Practice guidelines = Rules
- Non-formulary medication is Forbidden
- THIS IS HOW WE HANDLE SUCH PATIENTS!!!!

Heuristic Solutions

- What's causing the agitation?
  - What precipitates it?
  - How can it best be managed?
- Criteria for discharge
- Does the policy make sense in this situation?
- Guidelines ≠ Commandments
- What is the best pharmacological treatment?
- Let's work together to find a solution

Managing Antagonistic Patients (1)

- JUSTICE: **Their distrust leads them to become aggressive and menacing.**
  - **Menacing behavior is a psychiatric emergency**
  - **Use security, sedating meds (over objection PRN), restraint.**
  - **Use a security and/or 1:1 if needed**

- NONMALFEASANCE: **Admit it if you hate the patient (you are not alone)**
  - **It is okay to hate the patient**
  - **Admitting it helps you contain the feeling**
  - **Thus you take it out on the patient as little as possible**

- BENEFICENCE:
  - **Getting the patient through a medical hospitalization despite the personality disorder is a worthy goal.**
  - **Do not try to get patients to like or trust you or to overcome their personality traits.**

Managing Antagonistic Patients (2)

- **Splitting**: Some antagonistic patients will try to isolate all the perceived badness into some team members, while viewing others as good. Thus, have one team-member see the patient and deliver a consistent message (this person needs information and SUPPORT).
- Don't argue with antagonistic patients… it will exacerbate their distrust.
- Don't try to convince these patients that you are trustworthy. It will exacerbate their mistrust.
- Say calmly: "I can see you have little confidence in the staff. I recommend you try to put it aside temporarily so we can help you."
- Decide on firm consequences for unacceptable behavior. State these consequences nonjudgmentally and enforce them.

Managing Needy Patients

- **Realize and accept that you can NEVER satisfy the patient's emotional needs.**
- **Give only as much attention as medical needs demand.**
- **Do not respond to suffering, seduction, or clinging with more attention**
- **Gently set limits: show the patient that adherence brings the most attention and care from you.**
- **Reasons for limit-setting:**
  - **JUSTICE: limiting your response to treatment-defeating behavior frees you to care for patients with more urgent medical needs**
  - **NONMALFEISANCE: limit setting prevents you from getting drained, resentful and avoidant. You will better care for the patient medically.**
  - **BENEFICENCE: showing patient that a treatment-defeating pattern doesn't bring more care will decrease such behavior and serve the patient medically.**

Managing Dependent Patients

- Predictable, regular check-ins:
  - "I'll ask the nurses to check in every hour and I'll visit for ten minutes a day.
  - Otherwise, remember that the call button is for emergencies only."
- Portray medical adherence as the path to caring:
  - "I know it's hard for you to be alone here in the hospital. If you can get through the tests and studies that you need to get better, then you and I will sit down together and work closely to plan the next step. Until then, we must stay focused on your treatment. I will see you tomorrow."

Managing Masochistic Patients

- Reframe medical adherence as suffering
  - "It is really hard to be hooked up to an IV all day."
  - "This recovery will take a lot of time and perseverance."

- Reframe medical adherence as suffering for the sake of others
  - "Hip replacement is a major operation and the recovery will be very demanding. Nevertheless, I am recommending you consider it because you could resume babysitting for your grandchildren, and I know how much your daughter needs you."

Managing Histrionic Patients

- Reframe medical adherence as the most manly or womanly and attractive thing the patient could do

- Highlight how manly /womanly the patient is in a professionally appropriate way.

- Strike a balance between reserved /familiar

  - If too reserved, the patient will feel rejected and thwart treatment

  - If too familiar, the patient will ramp up the flirting or seduction until you MUST reject him or her, and then will be furious and thwart treatment

Managing the Narcissist

- Remind yourself that a sense of inferiority underlies the narcissist's haughty style. If you're great you don't have to tell everybody, do you?
- Never confront the narcissist with the fact that he or she is no more entitled than other patients.
- Use extreme respect, treating the narcissist as a person with special attributes and achievements.
- Emphasize your own expertise and behave in an extremely self-confident manner, assuring the narcissist that you are the best.
- Reframe adherence as a sign of the patient's superiority.

Patients who are *"special"*

- **Celebrities and Negative Celebrities** - caregiver dysfunction in reaction to the spotlight (the celebrity phenomenon)
  - Privacy of care
  - Media frenzies
  - Inappropriate entry to medical record
  - Celebrity entourage
- **VIPs** – caregiver dysfunction because of personal awe (the VIP syndrome)
  - Physicians (that is you, me, our families, our teachers, our mentors….)
- **Potentates** (and members of their coterie) - caregiver dysfunction is related neither to publicity nor to overidentification; crises over issues of power and privilege
  - see themselves as "big shots" and expect to be treated as such.

Alterations of care with *"special"* patients

The possibility of alcohol and substance abuse may be denied by caregivers (as well as by the patient and the family)

Issues of death, dying, and DNR orders may be neglected or handled oddly by caregivers

When protected from the normal hospital culture (and inundated with "important" visitors), the patient may suffer emotional isolation

Feelings of shame and fear in the sick role can go uncomforted by caregivers who forget their standard listening skills

Neuropsychiatric symptoms may be overlooked by caregivers not wishing to "insult" the patient

Personal issues of toileting and hygiene of the patient may be neglected or awkwardly handled by staff

Ordinary clinical routine may be short-circuited to avoid "inconveniencing" the patient, e.g., stool guaiacs crossed off nursing orders

Issues around sexuality may be avoided by caregivers, even in clinical situations well known to affect sexual function

Managing the special patient, the potentate, and the VIP

- **Don't Bend the Rules**
- Work as a TEAM, not in Silos
- Communicate actively and often
- Care should occur where it is MOST appropriate
- Resist "Chairperson's Syndrome"
- Beware of gifts and other seductions
- Avoid splitting
- Expect projective identification
- Manage communication with the media
  - Protect the patient's privacy and security
- Deal appropriately with the personal physicians of the VIP

People whose VIP status impacted on their medical care

- Eleanor Roosevelt (aplastic anemia treated with steroids when she actually had TB but they did not want to do a bone marrow as it would hurt)
- Michael Jackson (Propofol for sleep)
- President Gerald Ford (Diagnosis of inner ear infection when he had a stroke)
- President Ronald Reagan (numerous Secret Service agents in the operating room; lots of unnecessary noise)
- Joan Rivers (her doctor, not a member of the clinic where she had her endoscopy, was allowed to do a procedure)

Readings

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