I Hate This Patient: Managing Countertransference and the Difficult Patient

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SEPTEMBER 11, 2003

INTERNAL MEDICINE GRAND ROUNDS
UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER
AT DALLAS

Interests: Computerized medical education, psychosocial interviewing, evaluation and feedback of resident performance, mass casualty evaluation and triage, Persian Gulf illnesses.

This is to acknowledge that Robert Goldsteen, D.O. has not disclosed financial or other relationships with commercial concerns related directly or indirectly to this program. Dr. Goldsteen will not be discussing off-label uses in his presentation.

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Abstract.

Many studies have explored techniques for recognizing types of difficult patients and characteristics of difficult encounters. Few have identified the internal factors (variables) of the physician which, when explored, could greatly assist in providing a more satisfying encounter for both the doctor and the patient. A number of findings from medical research combined with studies from psychology and psychiatry indicate that physicians need additional awareness of their role in achieving positive doctor-patient interactions. Thus, this paper emphasizes the importance of increasing the physician's level of self-awareness so that he becomes more attuned to the impact of his statements and behaviors on his patients.

Furthermore, there have been a limited number of research efforts in the last half-century that discuss the interplay between psychological (psychoanalytic) variables and the difficult relationship. Few studies relate these variables to the medical model in which physicians outside of psychiatry practice. We discuss useful techniques that interrelate medical models, cognitive behavioral interventions, and psychoanalytic methods for better dealing with the challenging patient. We present specific cases that help demonstrate techniques in dealing with the difficult encounter, and extend methods to assist in teaching this topic to trainees.

Introduction.

Difficult patients abound in medical practice. Urban, suburban, rural, university and military physicians all encounter these patients. Needy, angry, emotional, somatosizing, and hostile, these patients demand an exorbitant amount of physician time, energy, and patience. Better understanding of how to work with these patients is needed to both preserve the professionalism and the sanity of the physician, and to provide the best quality care for this challenging population.

Surveys of physicians and research studies indicate that doctors have a strong desire to receive better training in managing these difficult patients.[1] Even traditional medical texts lack specific information on difficult patients. For example, Cecil's Textbook of Medicine does not even mention difficult patients in its overview of medicine.[2] Physicians note that they lack formal instruction, mentoring, and supervision from experts to develop mutually satisfying and productive relationships with these patients.[3] They feel their energies are better utilized for those who can either benefit from their interventions or appreciate their efforts.

A large body of literature exists in the psychosocial and psychological realms. Articles and studies since the 1950s looked at the characteristics of difficult patients, but failed to cohesively integrate the medical and the psychological models.[4,5,6,7,8,9,10,11,12,13,14,15] This paper attempts to do just that: integrate both bodies of information about difficult patients and present it in a manner that the provider can use. As doctors gain experience in identifying patterns that exist in these difficult patients, their levels of frustration, anger, and annoyance may well be diminished. Studies have examined physician beliefs and have concluded that they need to be better trained in dealing with the difficult patient to promote more satisfaction and less stress.[15] The techniques to be outlined can be applied to patients with any combination of difficult personality traits. The physician expands his knowledge base and clinical acumen by learning new management, interpersonal, and psychosocial skills and adding them to his armamentarium.

Findings about difficult patients.

Between 15 and 29.8 percent of patients are considered troubling by the doctor.[3,16] Generally, the amount of perceived difficulty is inversely related to the years of physician experience.[16] Residents and younger physicians are more likely to experience difficulty.[16,1] It can be postulated that older physicians are either more experienced in dealing with these patients,[16] set better boundaries, are better psychologically defended, are more skilled in eliciting psychosocial problems, or are too busy to allow these patients to be frustrating.[16] Nonetheless, older, more experienced physicians still find difficult patients to be problematic. Ninety two percent of general practitioners noted that they could use some assistance in handling difficult patients more effectively."[1] Doctors have also been asked to rate how they performed with the difficult patient, and they overwhelmingly responded that they needed help in learning how to re-gain control over the doctor-patient relationship, be less manipulated by difficult patients, and achieve better control of their anger and feelings toward these patients (countertransference).[1]

All providers have encountered patients that will repetitively refuse psychiatric referrals only to return with complaints laden with psychiatric overlays. Studies of difficult patients note that these patients are more frequent attenders to doctors.[17,18] and have more undiagnosed psychiatric disorders- including depression,[3] anxiety/ panic,[3] somatoform disorders,[3] and personality disorders.[19,3,20] Studies report a range of depression and anxiety from 22 to 29%.[1,3] They have greater alcohol and drug abuse,[20] and are more likely to be female.[17] Among patients with physical symptoms, only 1% were willing to consider a psychiatric explanation for their symptoms.[18] Other papers have noted the finding of an overwhelming denial by patients of emotional concerns that can be linked to illness in the "absence of physical findings."[14]

Jacobs, et al looked at the number of complaints in difficult hypochondriacal patients and concluded that 51% of patients in his study reported more than five complaints.[19] One-seventh of all patients in a given practice accounted for half of all doctor-patient encounters.[18] These patients have more symptoms than average, require more time for the physician to address their needs,[3] and have "fewer symptom-free days".[18] Difficult patients tend to use more medications and have a thicker chart. [17,21] They consume more health resources[4] and ultimately can increase the cost of health care.[20] Difficult patients have poorer coping strategies and more bland social lives.[18] They are more likely to be widowed or divorced,[17,21,4] older,[16,17,4] have a lower social class/socioeconomic status,[16,21] and have more psychosocial problems.[16,21]

These patients were also noted to have more medically unexplained symptoms.[11] As Kaufman and Bernstein noted in their seminal 1957 study: *A Psychiatric Evaluation of the Problem Patient: Study of a Thousand Cases from a Consultation Service*, 81.4% of random patients had psychological factors that were the basis for their complaints. Psychiatric disorder(s) accounted for either the primary or secondary diagnosis in all of these (814 of 1000) patients without any clinical evidence of organic disease after appropriate medical workup. In this subtype of difficult patients, the authors concluded, "emotional illness can and should be a positive diagnosis, not one of exclusion." [22].

Studies have also looked at those characteristics of doctors that increase the likelihood of having a difficult encounter. Low self-esteem resulted in doctors feeling more threatened by their problem patients. Also, as the patients evoked more emotional responses in these "low self esteem" doctors, the doctors were more troubled.[36] Merrill, et al looked at "troublesome aspects of the patient-physician relationship" and assessed doctors using the Kaplan Self-Derogation Subscale of the Rosenberg Self-esteem Scale and determined that the lowest self-esteem doctors were the most annoyed by the "difficult patient".[10]

A number of findings about doctor-patient interactions illustrate the many issues studied. Among them, this paper considers:

Control
Satisfaction/Needs and Expectations
Frustration
Environment
Purpose of symptoms

Control.

One of the most difficult aspects of the troubling medical encounter is the need for both parties to perceive they have some degree of control. Patients have personalities, behaviors, and symptoms that they bring to the encounter and these attributes are established and well-formed by the time the patient arrives in the doctor's office. It is generally easier for the doctor to adapt to the patient than for the patient to change for the doctor. Interventions that attempt to affect patient personality or style are usually not successful. Many physicians feel they need to regain control over the difficult encounter, set better limits, improve communication, and improve listening skills. On the other hand, patients often feel they lose control during the encounter.[11,1] The doctor controls the time, setting, and often agenda, while the patient also tries to control the agenda, their symptoms/ illness/ feelings, and to get the attention they want. This "battle" between patient and doctor for control and fulfillment of expectations can often be the root of the difficult encounter.

Satisfaction/ Needs and Expectations.

Satisfaction is another significant factor in working with difficult patients. Both the patient and doctor have desires to feel satisfied with the encounter. Patients wish to have their needs met.[3,12] Studies indicate that failure to address the concerns and (expectations) of the patient during the visit most strongly correlates with less patient satisfaction. [23] Marple, et al. studied patient concerns and expectations and found that 66% of patients worried that their symptoms represented serious illness; 78% hoped the doctor would prescribe a medication; 41% hoped for a referral; and 46% hoped the doctor would order a test.[23] These desires are not always verbalized by the patient and may not be elicited by the physician. For this reason, patients can leave an encounter dissatisfied, because their expectations have not been met.

Patients perceive their symptoms to be more severe and disabling than the doctor believes.[11,5] An increased incidence of common medical complaints including headaches, weakness, nausea, and dizziness were noted in difficult patients. Musculoskeletal and gastrointestinal complaints predominate particularly in patients with hypochondriacal tendencies.[19] Dermatological, otorhinologic and genitourinary complaints were less associated with difficult patients (P values of 0.01, 0.003, and 0.007 respectively).[3]

Patients are reported to be frustrated by the failure of their physicians to understand their needs and expectations,[3,12] and they may not understand the role that they play in the dissatisfying, difficult encounter. The physician also has needs that may not be fulfilled in the relationship. If their expectations are unmet, this can lead to frustration.[12] The doctor feels the need to be satisfied with his or her practice; has the need to problem solve; and has a need for "a sense of closure and satisfaction with their recommendations and intervention.[12] They also hope for an appreciative cooperative patient.[24] Physician frustration can result in patient avoidance," acting out", or unintentional mistreatment of the patient. A "vicious cycle" can result as the relationship spirals out of control. The poor interpersonal communication that results often leads to the doctor being

interpreted as having a lack of caring and empathy. Thus, the difficult encounter robs the doctor of the satisfaction that he craves. In general, difficult encounters provide the doctor with less fulfillment and make the practice of medicine less enjoyable.

Both patients and doctors want the other to engage with them in an emotionally, appropriate way.[17] Like many people, some doctors have a need to be liked, if not "loved," by the patient. Doctors who have difficult patients need to realize that they are unlikely to get the satisfaction/ admiration they unconsciously seek.

Frustration.

The feeling of frustration is yet another commonality between the experiences of doctors and patients. Doctors may be disappointed by patients' failure to recognize the effort, energy, or grief they may have experienced in dealing with the patient's medical complaint.[12] Also, frustration can result from the feeling of powerlessness to affect the outcome of the patient's illness or relieve symptoms. Since patients may have symptoms that are hard to characterize and therefore make it difficult to distinguish a minor illness from a serious illness, doctors are often confronted by communication and diagnostic barriers which may result in self-blame, frustration, and anger.[16] Additionally, physicians feel frustration when the norms of practice are challenged by patients. Patients may also report unrealistic goals for treatment which increases physician frustration.[24]

Walker, et al performed a study in a large rheumatology practice using the validated DDPRQ (Difficult Doctor Patient Relationship Questionnaire) and applied it to fibromyalgia and rheumatoid arthritis patients. This study looked at the characteristics of the patients and found that those who were rated as most frustrating, had a statistically significant increase in number of unexplained symptoms, increased psychiatric diagnoses, greater physical and social disability, and more impaired interpersonal coping. These patients also had an increase in prior adult victimization episodes including rape and physical abuse.[11] All these findings were bivariate correlates of physician frustration.

Environment.

The environment also contributes to the difficult encounter. First, the sterile, unfamiliar doctor's office can provide a foreign experience to the patient. Coupled with illness and health concerns, the patient may feel uneasy in this visually stark environment. The use of unfamiliar medical terminology combined with the surroundings contribute to the awkwardness of the encounter and may actually anger the patient.[24] The lack of privacy in many office settings can be an important factor that could cause conflict between a patient's and the doctor's personality. Such a situation may make a patient feel powerless, failing to know what to expect.[4] Furthermore, the onus is on the physician to create a comfortable atmosphere/tone. This setting should be conducive to mutual safety and trust that are necessary to promote the free exchange of information.

Purpose of symptoms.

A significant step in helping the physician improve the potentially difficult doctor/patient encounter is to establish an internal dialogue. He should ask himself "what is the purpose of the symptoms for this patient?" Sometimes attempting to understand the role that symptoms may play will help the clinician participate in patient care in a healthier, more adaptive way. Understanding the possible meaning of symptoms can promote empathy for the patient, improve rapport, and help the physician provide reassurance that real disease is unlikely. Another result of increased

understanding of the purpose of symptoms is the ability to "put into words" the patient's symptoms and feelings. This allows the provider to be less annoyed, frustrated, or angry with patients, particularly those with poorly defined symptoms.

Some patients believe that having symptoms "serves a useful purpose for them".[25] Again, patients often worry that symptoms "might represent serious illness."[23] They may also believe that having symptoms and obsessively worrying and reporting them in detail are somehow magically protective. They may believe, perhaps unconsciously, that meticulously and repetitively describing their symptoms will allow the doctor to have a better understanding of their "illness" and, therefore, catch the disease earlier in its most treatable form. This "magical thinking" can perpetuate extreme health awareness and operates much the same way superstition does in other domains. Many of these patients may have experienced significant loss. The loss of a close loved one solidifies the need for early evaluation and detection, and highlights the importance to them of stating their symptoms. Additionally, symptoms can provide patients with secondary gain including greater attention, focus, and special treatment.

As symptoms become more firmly emotionally embedded, patients may begin to define their view of themselves. Their core identity is linked to having the symptomatology. After a short period, the symptoms become familiar and safe for the patient, even though they may be painful and uncomfortable. For these patients, altering the view of the symptoms is analogous to changing who they are, e.g. if they rid themselves of the symptoms, they will no longer be "themselves" and their identity would be shattered. This holistic emotional and interpretive shift is particularly true with the anxious or obsessive-compulsive patient who can focus on physical symptoms in an attempt to channel his anxiety.

Definitions.

Definition of "**Psychosocial**"- (Webster's Dictionary, pg.924)—1) "Involving both psychological and social aspects. 2) "Relating social conditions to mental health, as in psychosocial medicine."[26]

In this paper, the term "**psychosocial**" refers to all aspects of a patient's life, other than physical symptoms or physical findings (e.g. physical exam, labs, x-rays...etc) that could possibly exacerbate or even cause physical symptoms and health problems. The aspects primarily include stress/sadness/loss in any of the following life domains: social (marriage, children, family, friends), work, financial, religious/spiritual. As noted elsewhere, many physicians trained in the medical model feel uncomfortable including discussion of this larger context in which the patient lives in their treatment of patients. Doctors may feel inadequate, ill trained to deal with it; may feel as if they would be opening up "Pandora's box;" or cope with psychosocial aspects of the doctor-patient relationship by avoiding to even think about it.

The term "**containment**" was coined by the psychoanalyst Wilfred Bion in the late 1950's. Further ideas that are associated with this term: It was originally used to describe the mother/infant relationship, but has since been extended to describe an active process between the analyst and the analysand; and, for the purposes of this paper, the patient and the doctor. *Containment* is the doctor's ability to deal emotionally with the patient's distress or any other negative feelings. The doctor, by allowing himself to feel the patient's distress to some degree and yet, not being destroyed by it, thus creates a safe place (*holding environment*) for the patient to express these feelings. It is not a passive function; it involves both partners in an active inter-relationship.[27]

The patient's feelings enter the doctor's mind and change it; and the doctor, as "container" of the feelings, also changes or modifies the patient's feelings in a more adaptive way. Thus, it's a two-way process in which both the patient and doctor influence each other's emotions. In analytic terms, the next step of this containment process defines **projective identification**. This phenomenon occurs when the doctor, having contained the patient's anxiety, sadness, frustration...etc, the disowned parts of self or feelings that are projected onto the doctor), and then is able to return the bad feelings to the patient in an attenuated, easier-to-handle form. In other words, the patient can reintroject the bad feelings that have been modified by having been more rationally and calmly contained or processed by the doctor. In a good doctor/patient relationship, the patient will be better able to tolerate the bad affects or feelings after the affects/ feelings have been contained by the treating physician. When this process occurs, it is often rather confusing for the physician in that he or she may not be aware until after the appointment that his mood has been greatly influenced by the patient. An example from the psychoanalytic literature may help clarify this process:

> " Money-Kyrle described a process in a session which started with the patient feeling useless and despising himself for that. The analyst felt somewhat at sea during the session and the patient showed increasing rejection and contempt for his interpretation. By the end of the session, the patient no longer felt useless, but angry. "It was I who felt useless and bemused," the analyst reported. The analyst was sufficiently disturbed by the patient's abuse of him, that it was only after the session, when "I eventually recognized that my state at the end was so similar to that he had described as his at the beginning."..."[27]

The psychoanalytic term "**countertransference**" is defined as any feelings evoked or "stirred up" within the doctor from the patient by either or both of the following: 1) The doctor's personal history and any issues from the doctor's past (e.g. a certain patient looks or sounds like someone the doctor didn't like from his past); 2) The doctor's reactions and feelings that are directly evoked by the patient's behavior, both verbal and non-verbal. Countertransference is a very powerful tool which when used appropriately, can help doctors find greater understanding and empathy for their patients, even the most difficult ones.

Brief History of Countertransference as a Therapeutic Concept.

Feelings elicited by the patient in the doctor were initially a problem for Freud and his colleagues. Early in his career, Freud had minimal interest in countertransference and only wrote four passages on the topic. He viewed countertransference as the "patient's influence on the analyst's unconscious"[28] and felt that it should be eliminated by the analyst's self-control.[29,28] Freud's first collaborator, Joseph Breuer, was so troubled by his countertransference that he abandoned the continued study of psychoanalysis because he was sexually aroused by his now-famous patient, "Anna O."[28]

Approximately 50 years ago, the concept of countertransference was broadened beyond the neurotic qualities of the analyst, and it now refers to any of the analyst's emotional responses, and has become an increasingly important issue.[29] In the 1930s and 40s, Balint and Fenichel both began writing about the interactive nature of transference and countertransference and repudiated the view of the analyst as a "blank screen", i.e. a neutral party without emotional responses.[29]

The well-known British psychoanalyst, Donald Winnicott, in a seminal 1947 paper entitled" Hate in the Countertransference"[30] emphasized that when a patient behaves in a hateful manner towards the analyst, it is the analyst's job to contain the hate or to consciously acknowledge feeling hate for the patient. If the analyst cannot do this, he saw the analysis as failed. A pivotal shift in thinking about the significance of countertransference to productive

work occurred in a 1950 paper by Heimann.[37 cited in 29] She writes: " the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's countertransference is an instrument of research into the patient's unconscious."[37]

Although other prominent analysts including Melanie Klein were skeptical about insights derived from countertransference, many of her followers have taken the lead in viewing countertransference as an integral and important aspect of the relationship between patient and analyst.[29]

Today, many of the major schools of psychoanalytic study, in particular the object-relations group, embrace the concept. They view the role the analyst experiences in the countertransference as both a normal facet of professional competence and part of his personal identity. The doctor plays a key part in the patient's fantasies and has his own conscious and unconscious world of ideas and feelings that he plays out with the patient.[29] The group referred to as the "contemporary Freudians of London" have been very interested in projective identification, a specific element of countertransference. Finally, analysts such as Thomas Ogden, of the Intersubjectivist school have taken countertransference to a new level in their work. They emphasize the interpersonal aspect of the doctor-patient relationship and believe that both parties contribute to a common creation that is specific to that particular doctor and patient.[29]

Psychosocial Problems.

As mentioned previously, many doctors feel unqualified, inadequate, or poorly trained to deal with psychosocial problems. As they gain more practice and experience, they may gain more comfort with psychosocial problems.[16] Furthermore, since many primary care training programs do not have an organized program for teaching psychosocial interviewing, doctors feel uncomfortable dealing with these patients.[31]

Ashworth, et al. performed a study that examined the internal beliefs of physicians and validated their own Physician Belief Scale with implications of how physician beliefs interfere with psychosocial interviewing.[16] Williamson, et al. looked at popular physician beliefs and noted that doctors are often worried that if they explore psychosocial problems, patients will become dependent.[31] Doctors also have concern about these problems because they require more time or effort then they are able to give; feel uncomfortable with the treatment; or fear that the patient may reject them for being too intrusive.[31] Studies note that up to 90% of patients would not complete a psychiatric referral.[13] Ultimately, many doctors wish to avoid psychosocial problems because they fear they will tend to accumulate more of such patients in their practice.[3] Doctors who embrace these patients tend to be more experienced in treating psychosocial problems and have been shown to have less troubling encounters.[3] Doctors that had more positive views and attitudes had improved interpersonal communication, and less troubling with patients with psychosocial issues.[32,3]

Case Examples.

The Angry/Hostile Patient
The Identified Patient
The Depressed Patient
Too Many Physical Complaints/ Medically Unexplained Symptoms
The Somatosizer
The Demanding Patient
Anxious/Hypochondriacal Patient

The Dependent Clinger
The Complimenter
The Entitled Demander
The Manipulative Help-Rejecter
Non-compliant patients
Rufuser
The Self-destructive Denier
The Threatening Patient

The Angry/ Hostile Patient.

Mr. A is a 52-year old male who has hypertension, diabetes, and coronary artery disease. Upon initial introduction, he notes, "I have had to wait 30 minutes to see you for this appointment!" He is notably angry and agitated. His body language: he is turned away from you and his arms are crossed with a stern face. He additionally complains that he called your nurse yesterday to ask for a MRI for his back pain before his visit with you today and he was told that he first had to have his initial evaluation. He angrily and flippantly notes that he has a meeting in 20 minutes and is always on time to his meetings.

The physician may have strong emotional reactions to this patient. Rather than responding in an angry manner, better ways are available to frame the feedback to the patient. A concept the doctor can employ when he has to verbalize tough unpleasantries to a difficult patient is a technique from couples' psychotherapy using "'I'-statements." This technique has been used to enhance communication and makes unpleasant feedback easier for the recipient to hear. "'I' statements" may be used whenever the physician wants to make a point about someone's behavior that is upsetting. You frame the statement in terms of the way it affects YOU or the way YOU respond to them. By doing this, (e.g., subtly shifting the onus for the bad feelings onto yourself), it often makes the other person, in this case the patient, feel less defensive and hopefully less angry. Instead of saying initially that YOUR behavior, (YOUR extreme anger, YOUR rude comments) are doing THIS to me, re-state the feedback. Acknowledge your feelings first [e.g., *"Mr. A., **I** am feeling _____ (upset, angry, defensive, confused...etc) at some of the things I hear you saying. **I** perceive that you're _____ (however you think they feel) and **I** need to address this with you. **I** am feeling ____ and finding it very hard to work with you right now."*]. This approach is subtle. However, by always starting the feedback with **"I"** statements you let the patient know that you are simply explaining how YOU feel by what YOU perceive to be going on. The patient is less likely to feel attacked, defensive, or accused.

Additional techniques for more positive communication with the patient include the use of the "feedback sandwich." In this technique, often employed by the military, patients accept the suggestions better if the physician frames the negative feedback between two or more positive statements. *Mr. A, I am very encouraged that you are in excellent physical shape which will really help you heal faster and make steady improvements with physical therapy for your mechanical lower back pain. Your lack of red flags on your physical exam makes a MRI scan not useful and your persistence to have one done is not appropriate for your level of symptoms and physical findings. You are clearly a very motivated and strong person that, in conjunction with the medicines and exercises that you will be given, will help you along the way.*

Another easy technique is called *mirroring* and involves repeating back to patients verbatim what they have said. It should not be used too often, as it can start to sound odd or contrived, but it can be a good way of defusing negative affect and letting the patient know that you are listening closely to him. Finally *reflective listening* involves hearing out a patient without interrupting and

paraphrasing back to the patient what you think you heard them say, and sometimes what you think they might be feeling. For example, the patient begins a tirade:

"*It took me 3 months to get this appointment and then I had to wait over half an hour to see you. Now, after this, apparently you don't think I need an MRI, and I know that I need one to make sure there haven't been any changes.*"

Having been involved in this type of interaction before, you sense that this situation is prone to escalation. Therefore you attempt reflective listening by saying something like, "*Mr. A, I'm sorry it took you so long to get an appointment to see me today and that you had to wait this afternoon. That must have been very frustrating for you. I also heard you say that you really believe you need an MRI scheduled to make sure there hasn't been any change in your condition and it sounds like you're concerned or upset because I told you that you don't need an MRI.*" This type of response again conveys active listening and a validation of the feelings you perceive the patient is experiencing, even if he does not directly state how he is feeling.

With regard to the patient's anger about waiting, the physician can say any of the following to defuse the anger:

1. *"I'm sorry for the delay; it's been an unusually busy morning."*

2. *"I don't like to keep people waiting. I'm sorry for the inconvenience and we're doing the best we can to make up the time."*

3. *"I'm sorry you had to wait longer than usual. I try to give everyone enough time to adequately address their concerns."*

This may or may not mollify Mr. A. He may continue over appointments to be angry, sarcastic, or to act in other ways that cause you to feel angry and to start to dislike him. For example he may "badmouth" other doctors, or aggressively challenge your suggestions. *Internal Messages* that the provider may think or give himself: "I really dislike this guy. But it's O.K., you cannot like all your patients. I'm sure anyone would find him to be a horrible patient, but I'm determined to address this appropriately with him." In this way, the physician has made himself very aware of his negative countertransference towards Mr. A. and has given himself permission to have these feelings. This can be liberating and prevent him from behaving in an unprofessional fashion. He should be allowed, however, to provide the patient with appropriate feedback. Some examples:

1. *"It seems to me that you're quite angry about something or at me, I'm not sure which. I'd like to talk to you about that -- because it's affecting me (e.g. I'm starting to feel angry, upset, frustrated...etc). I want to give you the best care possible, but we need to talk about how you're feeling and the effect it has on me and our relationship."* If Mr. A. denies being angry, calmly point out examples of verbal and non-verbal behaviors that lead you to believe that he is angry. Hopefully, he will eventually acknowledge his anger. If he blames you for his anger--e.g. *"Of course, I'm angry. None of you doctors has been able to figure out what the hell's going on with me!"*-- You may be able to validate his feelings of frustration and assure him that you are systematically going through differential diagnoses and that you are doing your best to get to the bottom of it. If appropriate, you can say that although you understand his anger and frustration, those feelings are starting to affect his relationship with you, and again re-state that you are "on his team" and are trying to help him.

2. You could briefly try to get at the underlying reasons for the anger (e.g. fear, loss of control, helplessness...etc) and address those feelings in a supportive way. This is a good way of containing the hostility, modifying it, and putting it back out there for the patient to assimilate (projective identification).

3. Sometimes the relationship with the patient cannot be salvaged. You just feel such dislike or threat from a patient that the situation becomes untenable. (Suggestion: You may want to consider consulting with a colleague about the patient before you reach this conclusion). For example, Mr. A. continues to badmouth you, threatens you physically or legally...etc.) Possible things to say: *"I'm sorry, but this relationship is not working. Neither of us is happy with the way things are going, and I don't feel that I can continue to see you and be helpful to you. I would like to refer you elsewhere."* This is likely to make the hostile patient angrier, but if you are adamant, he will have no choice but to "be fired." If Mr. A. is able to apologize for any of his behavior, perhaps you can say that if he can change his behavior, you will re-consider seeing him.

Identified patient.

The symptomatic patient may also have symptoms in the context of his family and interpersonal relationships. When the family system comes under stress, the identified patient gets sick in order to better bring the family together. The attention this family member receives diverts the family from their dysfunction and focuses their attention on the patient who is in the sick role. Each family member will assume their familiar roles in supporting this identified patient and thus avoid dealing with the family dysfunction.[20] An example of the role of the patient's symptoms is best noted in the following example:

ID is a 24-year-old Asian male who presents with his extended family for a visit. He has been having 2 weeks of sharp chest pain and palpitations. The patient exercises frequently without difficulty and has no risk factors for early cardiovascular disease. You discover that the patient lost his job 3 weeks ago and has had a significant amount of stress at home. At home, one brother is moving away to college and his sister has been having marital discord. The family notes they are concerned that I frequently experiences new symptoms each month and had missed too much work before his job was terminated. The mother, grandparents, brother and sisters all request you do "whatever it takes" to investigate I for cardiovascular disease.

What is strikingly unusual in this case is the family's level of involvement in his medical care. Further exploration reveals that ID is the "identified patient" and that he typically develops physical symptoms when his family is experiencing problems. Other patients may use symptoms as a form of attention getting. The symptoms may serve as a focus for the patient's emptiness or loneliness. Many older patients may seek medical care as an additional outlet for socialization.

Patients find an abundance of medical information based on a variety of sources, some good and some marginal with the easy availability of electronically-delivered medical information. This availability of information is often used in absence of medical knowledge, which may heighten symptom awareness and health concern. All forms of accessible information allow the patient to have health concerns much in the same way as a first year medical student may believe he/she has the disease they are studying. The major difference is that medical education provides both a setting of social support for the concerns, and the multitude of diseases taught can overwhelm the trainee's ability to assimilate the diseases into a dysfunctional (maladaptive), long-standing health concern. Ultimately, the behavior/concern extinguishes. Having the framework of broader understanding and knowledge of physiology and disease also limits the chronicity of the concerns.

It serves as a sort of desensitization process. Patients, on the other hand, do not have the benefit of this knowledge and training to alleviate their health concerns—a little knowledge is a dangerous thing!

It is important to remember that many symptoms are often very real to the patient, even if they are psychological. The clinician should understand that verbally ascribing a symptom, as "all in the patient's head" is mostly counterproductive. This is a sure way for the patient to perceive that the physician is unsupportive and ultimately ineffective in meeting his needs and expectations. This approach frequently results in the patient terminating the relationship and seeking a new provider. The patient could develop an even more entrenched perception that the physical symptom has an organic basis.

Depressed Patient.

A 22-year-old student, whom, as you walk in the room, you notice has a blank, expressionless stare on her face. The patient's voice is subdued. Upon questioning, she answers questions in a subdued manner with a simple "yes" or "no". After establishing rapport, she briefly hands you a list of medical problems that are quite extensive. Review of her extensive medical record notes a high level of health care use, having visited multiple medical providers for vague symptoms. After she asks you questions, and you discuss your assessments, she shows little or no response to your answers. Upon leaving this rather lengthy visit, you feel drained, discouraged and annoyed.

This depressed patient has projected her negative feelings into the physician and the physician has internalized them and, thus, by the end of the session he feels as discouraged and drained as the patient does. This is an example of projective identification. Psychoanalyst Robert M. Young colorfully describes the projective identification he experienced with a depressed female patient: "Another patient would come to a session, never looked at me, would speak one or two sentences and often remain silent for the rest of the session. It eventually dawned on me that she unconsciously wanted me to feel starved the way her mother had made her feel. I had been feeling that way, but it took some time to convert that sense into a thought. When I did make that interpretation, she slowly began to give more, though she remained likely to revert to sullenness and withholding..."[28]

A useful technique for the provider to better relate to the patient is expressing his countertransference to the patient. In this case the doctor may express to the patient his feelings of depletion and discouragement. This approach can provide the patient with useful information about how he is perceived and can serve as a starting point for addressing the patient's depression. In this way, the treatment plan can be broadened to include an exploration of psychosocial factors that may be contributing to the depression, a trial of antidepressant, or a psychiatric referral. Talking openly about the depressed feelings in the room also reduces stress and "burn-out" in the physician, because the doctor is not kept silently holding in the negative feelings.

Too Many Physical Complaints/ Medically Unexplained Symptoms.

A 24-year-old female marks on her screening form she has complaints of vague chronic pelvic pain, two pseudo-musculoskeletal complaints, headaches, allergies, poor sleep, fatigue, chest pain, shortness of breath, knee pain, bowel disturbances, dizziness, etc. Further introduction, and discussion of her complaints reveal too many complaints and expectations for this visit. Her descriptions of her complaints are vague and she uses a grating, demanding style as she persists in requesting all these problems be addressed during this one visit-- since she lives one hour away.

The doctor's initial feeling may be one of dread. It is very important to be aware that you have very negative feelings toward this patient.[17] A useful technique to use with this patient might be to negotiate expectations and ultimately set boundaries.[33] Every patient comes to the doctor with a pre-established set of beliefs of what their problems are and what could be a solution. These beliefs may be appropriate or irrational, but in either case the beliefs should be explored and ultimately reframed, if possible.[33]

The patient with multiple complex, poorly characterized symptoms, vague descriptions, and an abrasive style[12] are among the most difficult patients in clinical practice. This "terrible trio" should be identified early and many useful techniques can assist the provider manage this patient. The provider can start by trying to elicit the three most important or troubling symptoms using the "What Else?" technique.[38] This technique attempts to avoid additional concerns at the end of the visit. The provider takes the leadership role setting the agenda by asking *what else* is on their list of concerns. After each concern the doctor continues to ask "what else" until the patient has completely listed his physical complaints.[38] This technique is very useful for agenda setting, avoiding additional concerns and allowing the patient to verbalize their worries. The doctor and the patient can come to an agreement on which concerns should be addressed on that visit and which are to be saved for the future. When there is disagreement over which symptoms should be addressed, a compromise can often be reached.

Techniques to work better with this patient and improve communication include: being aware of your own, possibly unconscious, belief systems and how they can be a hindrance to care for this patient,[31] expressing how you feel,[17] and "identifying the behavior in the patient and call them on it."[17] In this case, the demanding persistence of the patient with an abrasive style. One option is not to say that you cannot help this patient; not refer to multiple other doctors; or even send her a letter noting there is "no room for her in your practice." Rather, all doctors have a duty to take care of their share of these patients in their practices.[34]

Frequently, progress in health improvement with this type of patient can stall. Therefore, a careful balance must be struck between setting boundaries, and establishing rapport. Once reasonable rapport is established, psychosocial interviewing may be initiated. Patients can use symptom diaries consider collaborative stepped care (use of social services, pain clinic, medical specialty referrals, psychological services), and cognitive behavior therapy. The provider should explore the following issues: "learning what the patient believes is wrong, the type of treatment expected, the hoped for outcome of the treatment, the cause of illness, the reasons for symptoms at any one time, the mechanism of the illness and symptoms, and the patient's understanding of the course of the illness and of its treatment."[39]

Cognitive behavioral therapy strives to reframe the patient's thinking about their "illness". It uses techniques that support the patient by helping relieve worry that grave conditions exist, acknowledge that the symptoms are "real", show understanding of the link between stress, anxiety, worry, and depression and the illness, support the negative effects that chronic pain medicines, tranquilizers, etc can have, and emphasize that managing symptoms may be a more realistic expectation then a cure. Ultimately, the provider should help the patient set short term and long-term goals and negotiate a treatment plan to invoke a behavioral change in the patient.[39] Regular, time-limited visits should be scheduled for these patients. Furthermore, if progress is not being made or you feel you can't help this patient, you may have this patient as a long-term member in your practice. All doctors have a duty to take care of their share of these patients in their practices.[34]

Somatosizer.

A 34-year old white female complains of years of multiple migratory musculoskeletal aches and pains. She denies any additional constitutional symptoms. Several providers have evaluated her for her symptoms in the past. She notes that at first she was convinced that she had the Epstein Barr virus resulting in chronic fatigue syndrome. She went through a period of time where she believed that her fatigue, which on a few occasions was associated with slightly enlarged palpable lymph nodes, was the early stages of HIV infection; she could not be convinced otherwise by previous providers. She now believes that she has an undiagnosed malignancy, and complains that she intermittently has abdominal bloating and discomfort that is relieved by mucousy bowel movements. She also has intermittent lower back pain with occasional electric shocks going down the back of her legs without any weakness, incontinence, or saddle anesthesia. She is convinced that she has a spinal tumor.

This patient may have a somatization disorder. But you are still obligated to look for an organic cause in an appropriate manner. Obtain a detailed list of the symptoms for the next appointment, including what factors exacerbate the symptoms, frequency, severity and duration.[24] "Attempt to elicit the emotional meaning of the symptoms..." for the patient.[40,24] Work to explore the patient's fears, concerns, and roles that these symptoms play for them. Be cautious in not moving too quickly to reassurance.[24] Consulting a colleague or psychiatric specialist may be useful in discussing the patient and developing strategies in management.

The Demanding Patient.

A 31-year-old female patient enters your office with a long list of complaints and proceeds to demand a full body CT scan and multiple blood tests that she got from the Internet (including some tests that would normally not be medically indicated). She requests genetic testing for breast cancer, even though she has no family history and a colonoscopy because her father 65-year-old father had a polyp last year after two prior negative colonoscopies. Upon questioning her further, she gets defensive and slightly agitated.

Never be coerced into doing anything that is not medically indicated. The best way to deal with this patient is to have a designated person in your office personally interface with this patient. These patients may have already identified a person who can best interact with them. This "buffer" can diffuse the patient's hostilities and be their ally. Explore the patient's underlying concerns about her body and fears about what a missed diagnosis means for them. Use the earlier rule to always attempt to rule out an organic cause.

Anxious/Hypochondriacal Patient with Medically Unexplained Symptoms (MUS).

Ms. A. is a 39-year-old white female who comes to you with a medical chart five inches thick and presents with non-specific pelvic pain. She's had several thorough gynecology and gastroenterology work-ups and all tests have been negative. During your meetings with her, she is extremely anxious, asks rapid-fire questions, interrupts you when you try to answer her, and is obsessed that she has some kind of gynecologic cancer that somehow has been missed.

What is transpiring in terms of countertransference and projective identification, and what do you do?

Countertransference: Some of the feelings evoked in a doctor by this situation may include anger, frustration, anxiety, overwhelmed, impatience...etc.) Again, it's very important to be in touch with how you feel when you are in the room with this patient. Sometimes it's helpful to view the patient's

behavior with you as a microcosm of how she is all the time in her daily life. This may help you to step back and examine the behavior more objectively and keep you from taking it personally. Chances are that if she is obsessive and anxious with you, she is like that across people and situations. Awareness and acceptance of countertransference helps us use it therapeutically and not inappropriately. Projective identification: Ms. A. is projecting into you, the doctor, a variety of feelings that you begin to feel acutely, e.g. anxiety, frustration...etc. As doctor, you work on containing her feelings and giving them back to her in a way that is hopefully helpful to her.

Examples of things to think about her behavior to help you re-frame or think about her behavior in a different way:

1. Ms. A. is terribly scared that she has cancer, is fearful of dying at a young age and her anxiety, which has become increasingly annoying to you, reflects an existential fear of death, which we as humans all grapple with. This may increase compassion for her. You may wonder and try to find out if anything in her history (e.g. loss, separation) contributes to this fear in such a heightened way.
2. Ms. A. feels very helpless and out of control about her ongoing pelvic pain and her continuing search for doctors and tests is her attempt to be reassured and to gain control of her body/health.
3. Again, tell yourself that although her behavior may be magnified with you as doctor because she is hypochondriacal, that she, in all likelihood would be anxious and obsessive with everyone. It's not personal about you, per se.
4. Assess for untreated anxiety disorder and see if referral to address this is appropriate. (See Appendix A: "Buzz Phrases" section on possible ways to frame this).
5. Wonder about, and if appropriate, later ask about any other specific personal meaning her symptom has for her, other than the fairly obvious fear of cancer/death.

Here are some important examples of approaches for discussion with Ms. A. Through these discussions, a doctor can indicate you are capable of containing her negative feelings and are not afraid to discuss them with her (e.g. returning her feelings in attenuated form so she can re-introject them and hopefully be comforted).

1. Continue to provide reassurance. Discuss with her that serious disease, like cancer, does make its presence known through blood work, CAT scans, other tests...etc. and that it's VERY GOOD NEWS that all her work-ups, which were thorough, have been negative. Assure Ms. J. that if there is any change or worsening of her symptoms that you will take it seriously and run tests as appropriate.

2. Inquire about her history and see if there is any objective reason in her past that heightens her vulnerability to hypochondriacal behavior. (e.g. "It makes a lot of sense to me that you would be worried about cancer given that your maternal aunt had ovarian cancer.")

3. Address gently but unapologetically, the possibility that her pelvic pain worsens when she is upset, sad, stressed...etc. and inquire about psychosocial aspects of her life in order to tease out any mind-body link in the symptom.

4. You can preface this next by saying, "I know this may sound like an odd question, but bear with me, because sometimes this really is going on, although you may not know it at first, with people and their aches and pains." Ask her if the pelvic pain could possibly have any other meaning for her, other than her fear of cancer and an early death. She may look at you blankly and say, "I don't know what you mean" or snidely respond, "Are you a shrink or

an internist?" or sarcastically comment, "Gee, and you're the doctor. Shouldn't you be the one to figure that out?" For the moment, try to ignore this and be persistent in asking her to think about this question. You can briefly explain that in some cases, although symptoms are definitely real, when there's no organic cause to be found for them, that the pain symbolizes something the patient is concerned about. And that if what the symptom represents can be discovered and talked about, then often the symptom diminishes in intensity or goes away altogether. Ask her to "*free-associate*" (or say everything that comes to mind) when she experiences the pain, talks about it, reads about pelvic pain...etc. This may be fruitful. However, if Ms. A. is unable to do this, it's best to let it drop, later suggesting a psychiatric referral if appropriate. Perhaps just your bringing this up, will have "planted a seed" in her mind that she may someday come back to and make use of.

5. At some point later in the relationship, when there's more rapport established, if her annoying obsessiveness persists (and more than likely it will) again, make use of your countertransference productively. Try gently telling Ms. A. (if possible, using "I" statements), that although you understand her discomfort and concern, that her anxiety and interruptions and intense questioning are difficult for you to hear. To some extent they interfere with your relationship with her and that you find it hard to listen to what she has to say when she questions you in this way. Hopefully, she will want you to be able to fully take in what she has to say and eventually develop more insight into how her anxiety is affecting you.

The following "subtypes" of difficult patients have been described in detail by Groves, J.E. in his 1978 article in the New England Journal of Medicine entitled "Taking care of the hateful patient." He writes," 'hateful patients' are not those with whom the physician has an occasional personality clash. As defined here, they are those whom most physicians dread. The insatiable dependency of 'hateful patients' leads to behaviors that group them into four stereotypes..."[41] For each group of patients, Groves suggests specific approaches in their management, with the goal of attaining the best doctor-patient relationship possible under the circumstances.

The Dependent "Clinger".

This group of patients is described as never being fully satisfied with the doctor's efforts and attention. The more energy the doctor expends, the more needy the patient becomes.

An exceptionally beautiful, single, 32-year-old female, Ms. DC, consults a male internist for "constant fatigue." Eventually, after a thorough work-up, he diagnoses her with lupus. The physician spends a lot of time with her initially, explaining to her that she has a mild form of the disorder. She thankfully compliments the doctor's fine diagnostic acumen and superb bedside manner.

In terms of early countertransference, this doctor experiences some erotic feelings of attraction towards her. After she initially responds intelligently to his explanations by asking some pertinent questions related to prognosis and asks him to continue treating her long-term for this chronic illness, he feels flattered and touched and agrees to do so. One could speculate that in terms of projective identification, Ms. DC. is unconsciously aware of this physician's desire to feel special and loved, and is projecting out her neediness/dependence, which initially is a feeling the doctor is pleased to assimilate or contain. In this vignette, Ms. DC's intense neediness is not at first apparent, but progresses rapidly over time. Later on the same day of the appointment, Ms. DC calls briefly to thank him for seeing her. During the next week, she calls twice, once to thank him again and once because she was feeling worse than usual and was anxious about dying. Over the next month, Ms. DC begins to leave more and more messages for the doctor and calls the receptionist

several times to try and arrange more frequent appointments. Soon, the doctor's countertransference turns to annoyance and then dread of her phone calls. After two months, Ms. DC. is calling the doctor daily, both in the office and at home, having somehow found his home number.

Groves discusses early signs of the *"clinger"* which include expression of gratitude, but to an extreme degree and the doctor's countertransference feelings of specialness and power to the patient. As time goes on, however, the countertransference changes and also the patient's feelings for the doctor, or transference changes. Groves writes, "the doctor becomes the inexhaustible mother; the patient becomes the unplanned, unwanted, unlovable child."[41]

To rectify this type of "bottomless pit of need"[41] relationship, the physician should tell the patient as early in the relationship as possible with tact and firmness, that the doctor has limits on knowledge/skill as well as time and emotional stamina. This type of patient requires the setting of firm and consistent limits that may need to be repeated many times. Follow-up appointments are scheduled at the completion of the current appointment, and the patient is firmly reminded to only contact the physician during office hours or in an emergency.

Dependent Clinger subtype--The Complimenter.

A 55-year-old businessman, Mr. C., begins every session complimenting your hard work, dedication, and empathy. He then launches into long list of complaints. Upon addressing 7 of them and then spending 20 minutes longer than the prescribed appointment time, you proceed toward the door and the patient notes he thinks you are the best doctor he has seen, but indicates that he has more issues to address. He again expresses his deep appreciation and admiration of your skills to keep you in the room.

This very manipulative behavior will also often result in frequent phone calls, and repetitive visits that could ultimately lead to dependency on the physician. This passive dependent patient, whose expectations and needs exceed the physician's time, energy, and capabilities,[24] often has an infinite void that can never be filled. This Dependent Clinger group of patients displays behavior from the mild, appropriate requests for reassurance to the constant, desperate entreaties for all forms of attention. They do not seem to be aware of their effect on the doctor (e.g. the negative countertransference that they evoke), and whether they have no discernible illness or serious medical problems, their needs can never be fully satisfied, and they tend to perceive the doctor as inexhaustible. The doctor soon may develop "a sense of weary aversion" toward the patient. When the doctor finally tolerates all he can and strongly suggests a psychiatric referral, the patient correctly sees this gesture as a rejection and is not likely to accept the referral.[41]

The Entitled Demander.

This group of individuals resembles the "clingers" in the depth of their neediness, but they do not come across as flattering or unconsciously seductive as is typical of the former group. The demanding patient uses different "tools" including intimidation, devaluation, and the induction of guilt to put the care provider in the same role of inexhaustible supply of time and energy. Entitled, demanding patients are usually quite aware of their effect on the doctor, unlike clingy patients, and often attempt to maintain control of the doctor by threatening punishment. This can take the form of withholding payment or threatening litigation. Interestingly, the demanding patient is typically unaware of the deep dependence on the doctor that actually underlies these attacks. That is why it is helpful for the physician to consider that these patients' hostility may stem from a primitive fear of abandonment. Alternatively, the hard-to-take entitled attitude may be resorted to (demonstrated) in

an effort to preserve the sense of self in a world that seems hostile to them, or during what seems to them a very frightening illness. As mentioned previously, sometimes ascertaining the underlying emotional motive for even the most maddening behavior can lead to greater understanding and compassion on the part of the doctor.

These patients often also behave in an exasperatingly superior manner, as if they innately deserve everything. Groves believes that this tendency serves as a defense from awareness that the doctor seems to have ultimate power, over life and death itself. An interesting dynamic may occur in the physician's countertransference toward these patients. Over time, the doctor may become fearful about his reputation, extremely angry that the patient is not grateful or cooperative, and eventually, may develop secret feelings of shame, as if the patient's devaluating comments and demands were actually realistic (e.g. "I must not be a good doctor since I do my best and still this guy isn't satisfied and tells me it's not good enough").

The impulse to "act out" the negative countertransference by pointing out to the patient that he/she deserves no more than the next person is typically unproductive. In fact, if one views the entitlement as a defense that supports the patient during a perceived frightening illness, making a comment about the patient not being especially entitled, breaks down the defense, and may be emotionally devastating for the patient. Groves suggests a more helpful strategy involving supporting the patient's entitlement, but re-directing it towards the course of treatment.

A 58-year-old high-powered attorney, Mr. E., becomes enraged when he is eventually diagnosed with colon cancer. Mr. E. seeks continuing consultation from different doctors, refuses to understand the nature of the illness, and threatens to sue various doctors when he does not like their explanations of the disease, the treatment, or his prognosis.

The intense countertransference evoked in his physicians was fear, discouragement, and depression, and many of them acted on these feelings by delaying in returning his phone calls to schedule appointments. In terms of projective identification, this patient, underneath his hostile, demanding behavior, was feeling helpless and afraid and he successfully projected these emotions to his caretakers. Because Mr. E. was a prominent and successful lawyer, his physicians were fearful that he would sue them for "negligence" or "failure to diagnose."

A more helpful approach is to address the patient's underlying emotional state, whether it's anger, fear, helplessness...etc. and to re-channel the sense of entitlement to further the patient's treatment. An example of what to say to a patient like Mr. E. is as follows:

" I know you're angry about your illness and mad at the other doctors and you have a right to be angry. You have an illness that makes many people give up, but you are fighting it, and I admire that. However, you're also fighting your doctors and we are on your side! You say that you're entitled to certain tests, certain types of chemo...etc. and you are. You are entitled to the very best medical care we can give you. But we won't be able to give you the good treatment you deserve unless you help us. You deserve a chance to fight this disease and to have us as your allies in beating it. And Mr. E., you will get the help you deserve if you stop misdirecting your anger towards the very people who are trying to help you get what you deserve. We are on your team and it's our job to give you the best medical care we can, so please help us to do this."

Taking an approach like this acknowledges the patient's entitlement, but directs it away from the need to have unreasonable demands met or controlling others, and focuses it on entitlement to realistically good care. Groves also recommends that in cases where litigation is threatened that

physicians practice "defensive medicine" (e.g. thorough documentation) without becoming defensive in interacting with the patient.[41]

The Manipulative Help-Rejecter. (Also commonly referred to as the "Yes, but…", group)

These individuals appear to feel that no recommendation, treatment, or regimen will help them. At times, they may seem almost smugly satisfied as they come back on their next appointment and report that once again, the doctor's recommendations did not work. Their negativity and pessimism may increase in direct proportion to the doctor's efforts and enthusiasm. Often, if one symptom goes away, another mysteriously appears. These patients are not really seeking symptom relief, but want to use their symptoms to maintain the doctor-patient relationship, even to a degree of masochism.[41] In other words, there is often an underlying deep dependency on the relationship. These people are often depressed but frequently deny this and unfortunately, typically refuse psychiatric referral.

A 68-year-old female with no significant past medical history returns with complaints of a "trickling" sensation localized to her entire left arm below the elbow. She describes the sensation as a feeling of hemorrhaging. The patient has been worked up extensively with MRI scans, nerve conduction studies, cervical spine films, neurologic and orthopedic evaluations, EKG's, an EEG, stress tests, etc. and still notes that she has "something wrong" with her. She reports that she has followed every past doctor's recommendations and nothing has helped her. This visit she complains that she must have a vascular problem. Upon examining her and explaining that she does not have a definable etiology of her sensation, and reassuring that all concerning etiologies have been ruled out, she proceeds to plead with you: "Please don't give up on me; all other doctors have given up on me. You are my last hope."

In terms of countertransference, the physician may first experience anxiety that a treatable illness has been overlooked. Then the doctor's feelings may turn into irritation, and eventually into self-doubt and depression. In terms of projective identification, one can conceptualize that these patients are projecting parts of themselves that they don't want to acknowledge or "own", specifically helplessness and depression. The physician is the recipient of these negative feelings and often ends up holding these emotions for the patient and feeling the same way that the patient unconsciously feels.[41]

It can be helpful to "share" the pessimism by acknowledging to the patient that the treatment may not fully cure their condition and that regular follow-up visits (schedule controlled by the doctor) will be necessary to maintain any partial improvements. By taking this approach, the patient's underlying fear of losing the doctor may be somewhat allayed and he may be able to follow the treatment plan without being afraid of contributing to his own abandonment.[41]

Doctors frequently encounter the pathologically dependent, manipulative patient with an Axis II diagnosis of Borderline Personality Disorder. Groves defines "manipulativeness" as "an intense, covert, contradictory, self-defeating attempt to get needs met."[41] Some patients have unconscious conflicts about closeness and distance from others and at the same time that they try to get close to the care provider, they are trying to maintain a safe distance from the source of emotional support. Certain extreme borderline patients feel so "empty" inside that paradoxically, to get their needs met, threatens them with engulfment to the point that they do not feel alive. They are simultaneously fearful and craving of connection. These patients are notoriously difficult to treat and bring up much negative countertransference in their doctors. Clear and firm limits should be set on unrealistic expectations and demanding behavior. Also, the doctor can discuss entitlement issues in a similar manner recommended with the entitled patient. Gentle, clear and

simple reasoning is more helpful than long explanations. By behaving in a firm and consistent way, the doctor can often convey that the patient will be connected to the doctor at an appropriate level—e.g. not so close as to cause the patient to feel engulfed and not so distant that the patient feels "starved" for more contact. To help this type of patient accept a psychiatric referral, it is recommended to schedule another appointment for the patient after the consultation, so that the patient will be less likely to feel abandoned.[41]

Non-compliant patients are also subtypes of Help-rejecters who will usually fail to fill or refill the prescription, and often return for the same problems.

A 70-year-old female with multiple medical problems, continually fails to fill your prescriptions, and keeps returning for the same problems you have already addressed.

This patient is being passive aggressive in that they act as if they will follow through with the suggested regimens but do not. It is important to remember that the amount of pressure one places on a patient to comply with the treatment regimen should be proportional to the severity of the patient's health problem(s). The more serious the health concern, the more the physician is obligated to explore the reason for the non-compliance with the patient. There are a number of reasons for a patient's non-compliance and each one demands a different physician response: (1) the medications are too expensive. If appropriate, the physician can discuss possibilities for obtaining the drugs at a reduced cost. (2) The patient's depression has caused indifference to his health. In this case, an exploration of psychosocial aspects of the patient's life and a discussion regarding a trial of antidepressant may be feasible. It is important to express concern for the patient and his situation. (3) Mental or cognitive disorders such as dementia may impair the patient's capacity to comply with treatment. The physician should enlist the support of the patient's family members and if possible, tell one or more family members that the patient cannot be seen without a family member present at the appointment. (4) The patient has a low I.Q. or another impairment such as Attention Deficit Disorder (ADD) which prevents him from fully grasping the health consequences associated with non-compliance. The doctor can repeat as many times as necessary in clear, concise language specific ways in which the patient's health is likely to suffer if he does not follow the prescribed regimen.[35] (5) The patient distrusts the physician or the health establishment. This most commonly occurs early on in the physician/patient relationship and improves as rapport and acceptance develops.

The Refuser.

This is a 35-year old black male with a strong family history of early coronary artery disease and diabetes who presents for his third visit, with each visit having diastolic blood pressures greater than 100. On prior visits, when antihypertensive therapy was recommended, the patient refused medications, noting that he had" white coat hypertension" and negotiated to work on diet, exercise and "controlling it on his own." Each visit, he fails to bring in his home blood pressure readings that were requested from the prior visit. On this visit, the patient is noted to have a severe elevation in his lipids. Your attempts to discuss the reasoning for antihypertensive therapy and antihyperlipidemic therapy reveal that the patient is again "not yet ready" to start medication.

This third type of patient is slightly different from the others. Just as the non-compliant patient does not follow the doctor's instructions and the help-rejecter fails to derive benefit from therapy, the refuser rejects all interventions often openly and defiantly. Despite the doctor's attention and time explaining the benefits of therapy, these patients often view themselves as being the regulator of their own body. They wish to gain control over their lives by attempting to manage their ailments. They believe that their sheer strength and force of will can prevail over illness. The

best approach for these patients is to explore their beliefs about their illness and rather than proceeding with a lecture about the merits of therapy, appeal to their strength, self-sacrifice and stoicism. Often negotiation will prove fruitful as long as they leave the encounter with their sense of control intact, having gained something in return for their compliance. Without appropriate care, these patients will become "non-compliant" patients. They will soon find out it is easier to accept therapy and not carry it out rather than listen to the recurrent "preaching" or "lecturing" of the physician. These patients often reject the provider's best intentions because of their unconscious reflection back upon prior victimization episodes. They may develop transference to the doctor attempting to "defend themselves against feelings of powerlessness and helplessness…(having) internalized aspects of the powerful abuser."[17] These patients view themselves as a victim, placing the doctor as the victimizer.

The Self-destructive Denier.

This group engages in "unconsciously self-murderous behaviors" such as the alcoholic who continues to drink despite multiple serious health concerns. Groves contrasts the above with what he terms the "**major deniers**" who deny their health problems without any self-destructive intent. These people use the defense of denial in an attempt to survive. They typically prize their independence and resent the restrictions imposed on them by having a medical condition. The doctor's countertransference towards these patients is often feelings of anxiety.[41] For this type of denial, one should go along with the denial to some extent by appealing to the patient's sense of heartiness and tying it into the medical regimen or treatment. For example, saying something like, " I know that avoiding that kind of exercise after a meal is hard to do, but you're obviously a tough and determined person and I know you'll be able to remember that and stick to it." The doctor should deliver advice *lightly* and focus on maintaining health, rather than taking a more authoritarian "doom saying" approach, since the patient will just deny any bad news.[41]

IE is a 31-year old homeless alcoholic Hispanic female who is brought into the Emergency Room by the ambulance, mumbling and talking to an imaginary friend. This is the fifth visit this month for various problems including cirrhosis, Hepatitis C, and gastritis with varices. She now complains of a headache and stiff neck. After being examined, she is combative and does not allow the nurse to take her vital signs. She is adamant about refusing a CT scan or lumbar puncture and, as always, wants to leave.

Individuals who seem bent on their own destruction are much more difficult for any physician and the doctor may feel downright hatred and malice toward these patients. He may have thoughts like, "I wish he would just go ahead and kill himself already and get it over with!" Again, having the thoughts and the awareness and acceptance of the negative feelings stirred up, is the first step to using the feelings therapeutically. These self-destructive patients are, like the other three subtypes, deeply dependent and appear to have given up hope of having their needs met. They seem to take pleasure in defeating their doctor's efforts to preserve their lives and may exhibit a chronic form of suicidal behavior, sometimes letting themselves die. When this type of patient does die, there is often audible relief, perhaps even happiness on the part of the medical staff.[41]

What a doctor can do for this type of patient is really quite limited. However, a good start, as mentioned above, is to recognize without shame, guilt, or self-blame that such patients provoke extreme negative countertransference reactions in their providers. The physician may feel caught between the ideal of rescuing the patient and the dark, perhaps abhorrent wish for the patient to die. The more the doctor is consciously aware of the negative feelings and accepts that they are not abnormal, the less guilty and conflicted the doctor will feel. He will also be less likely to "act out" his aversion and provide better care to the patient. If appropriate, the physician could comment to

the patient that based on the history, the behaviors, the non-compliance…etc, that it truly appears to the doctor that the patient does not want to live and to explore that with the patient. The doctor may have to come to grips with the possibility that the patient does in fact want to die. Of course, a psychiatric consultation to treat depression would be optimal, but these patients, too, are usually resistant to accepting the referral.[41] The physician would also benefit from discussion of the negative countertransference with a colleague or psychiatrist in order to "air" the feelings and fight the impulse to abandon the patient. Understanding that this type of patient would be difficult for any physician, no matter what discipline or how well-trained, may help the doctor to feel less guilt, self-blame, dread, or sense of defeat.

Groves writes that these kinds of patients are so difficult because their behavior forces the doctor to face very intense hateful feelings or to spend a large amount of mental energy trying to deny or disown these feelings. What is important about these patients' behavior is that it teaches the physician that what counts is how the doctor behaves toward them, not how he feels.[41] Awareness and acceptance of even powerful negative feelings helps prevent unprofessional or unethical behavior while treating these patients. Negative countertransference constitutes important clinical data about the patient's psychological issues. Also, when the patient creates in the doctor (through projective identification) feelings that are denied or disavowed, errors in diagnosis and treatment are more likely to occur. It is easier to deny negative feelings than to face them but Groves argues, and we would agree, that disowning the countertransference wastes clinical data that is ultimately helpful in treating these so-called "hateful patients."

The Threatening Patient.

This is a 50-year-old attorney with a history of periumbilical abdominal pain who comes in with expectations of a full and detailed workup of his discomfort. He sardonically notes during his conversation that, "if you mess up, I will sue you." He notes that he had had blood work, a CT scan, and a colonoscopy in the past all of which has been normal. You are faced with the dilemma of having to order an extensive battery of tests versus a more conservative workup. A phone call a week later reveals that, "My pains are not getting any better." You decide you what you have to do.

With these patients, the key rule is to practice thorough documentation of every contact with the patient. The notes should contain a detailed description of the content and tone of every appointment or telephone conversation. By doing this, it is likely that the physician will be prepared and able to defend any clinical decisions should the patient actually carry out the threat of litigation. Many of these patients have felt deep dependency on their providers in the past, only to be rejected. Many of them have fear of being abandoned again. Reassuring them that you are/ have been taking all reasonable steps to address their complaints, and instilling trust and mutual respect will soften their acerbity.

Subtypes and patterns of difficult patients have been discussed. The techniques presented should be practiced, applied and taught.

Balint Groups
Education

Balint Groups.

One suggestion for teaching medical staff how to respond more empathically and therapeutically to difficult patients is to expose them to the ideas of Balint Training. This approach was developed in the early 1950s by Michael Balint, a Hungarian physician and psychoanalyst at the Tavistock Clinic in London. Balint Training is a well-developed method of understanding the

doctor-patient relationship which highlights the increased therapeutic possibilities when doctors communicate skillfully with their patients. Balint was interested in the psychological implications of general practice and devised a group-training format for physicians to gain a better understanding of these implications.[42] Because he was trained as an analyst, he emphasized the importance of the doctor's countertransference as a very useful tool for increasing understanding of the patient and the doctor-patient relationship.

The format of Balint training is a weekly, typically hour-long meeting of physicians, coordinated by one or two trained leaders. When Balint first started these groups, they were led by one or two psychoanalytic consultants. Their job was to help the doctors with their difficult cases by exploring the doctor's options in assessment, in treatment, and in following the case in their practice. The aim was to "help the doctors to become more sensitive to what is going on, consciously and unconsciously, in the patient's mind when the doctor and patient are together."[43,44]

The agenda for each meeting is set by the cases which the participants bring for discussion. The criterion for presentation consists of the treating physician regarding any situation as a problem that obstructs the successful management of the patient or patient care or causes the physician to feel psychological discomfort. Examples of relevant topics include most of the areas discussed in this paper such as: psychological problems in the patient, including personality disorders; difficulties in the doctor-patient relationship; difficulties in the family of the patient; and even problems in the doctor-colleague relationship (e.g. a physician has a disagreement with a colleague in the practice over how to appropriately manage a case).

This type of group learning process is helpful in allowing physicians to realize that they, like all people, have "habitual responses"[42] to certain types of patients and issues. The goal is thus to motivate group members to examine their existing approaches and to explore alternative ways of responding.[42] Another key element of this training is the emphasis on listening as an active and critical skill and learning how to limit interruption of patients.

As an analyst as well as a general practitioner, Balint was keenly interested in how general practice could benefit clinically from the contributions of psychoanalysis. He wanted the physician, like the analyst, to appreciate that at any time, either the doctor or the patient could start relating to each other out of the context of their separate pasts (transference and countertransference).

The American Balint Society that was founded in 1990, now credentials leaders on an ongoing basis at 3-day workshops.[32] We believe that incorporating Balint groups or groups with a similar process and function into medical school and residency curriculums would be an excellent start to training future physicians. It is hoped that this would lead young physicians "to a more precise, empathic, and practical understanding of doctor-patient interactions and difficult patients."[42]

Education.

Educating physicians about countertransference and its therapeutic use with patients promotes Increased self-awareness and attention to how one responds emotionally to patients. These skills also enhance patient care in that they humanize the doctor-patient relationship and allow physicians to provide better treatment. Smith[45] discusses the need for better training for second and third-year medical students in countertransference to help them increase competence in conducting clinical interviews.

Smith's study of medical students found a very high incidence of unrecognized feelings toward patients which sometimes led to potentially harmful behaviors associated with the feelings. The students were studied individually during a clinical interview each student

conducted. The most common unrecognized *emotions* included fear of harming the patient, fear of loss of control, performance anxiety, and idiosyncratic concerns, such as fear of developing the patient's illness, such as cancer. One or more of these feelings was found in nearly all of the students, and interview behaviors that were potentially damaging were observed in the majority of the students. Examples of these *behaviors* included avoidance of relevant psychosocial issues and/or excessive control of the patient, which had the effect of suppressing the patient's reporting of psychosocial data. Serious problems could occur when a clinician, as in this study, misses vital information about suicidal ideation or intent because he unconsciously avoids the subjects of depression and death. Avoidance of discussion of certain symptoms that were essential to fully understanding the patient was seen in this study.[45]

Although all students in this study had previously demonstrated adequate interviewing skills, the unrecognized feelings led to impaired interview performance. Smith recommends that medical training in understanding countertransference and the effects on behavior involve an experiential approach instead of just "cognitively directed teaching".[45] An experiential approach, similar to Balint training, would allow the student, resident, or physician to be helped by a supervisor to experience and become more aware of his feelings. Greater self-awareness can then lead to understanding the effect of these feelings on patients and on how to manage the feelings. Smith also draws a connection between physicians' general avoidance of psychosocial material in patient interviewing and their lack of training in how to handle their own emotions that may arise during discussion of psychosocial issues.

Summary.

In conclusion, there is a greater need to extend methods and teaching strategies in managing the difficult patient to both experienced and junior physicians alike. Methods for management of these patients predominate in the medical model and more emphasis is needed in the psychological and psychosocial realms. It is imperative that physicians in training learn improved techniques in working with difficult patients and have the mentoring, supervision, and support to preserve their sanity and improve quality of care. Physicians must develop increased awareness of their feelings in response to the patient (countertransference) and understanding of the ways in which patients project their feelings onto them (projective identification). Levels of frustration, anger, annoyance, helplessness, guilt, and anxiety can be attenuated with the development of proper skills.

Doctors should gain experience in identifying patterns of patient behavior that recur across a range of interactions. As one author noted, 92% of physicians surveyed acknowledged that they could use assistance in working with these difficult patients. Exploration of psychosocial problems is key to discovering the origin of physical symptomatology for many difficult patients. Doctors need to be aware of their own belief systems that are an impediment to exploring psychosocial issues.

Between 15-29.8% of all patients are difficult and comprise half of all physician encounters. Therefore, at least fifty percent of the time the doctor may be interacting with such patients. Psychopathology is prevalent in many typologies of the difficult patient-- in one study over 81% of patients had a psychiatric disorder as either the primary or secondary diagnosis. Furthermore, since only 1% of patients are willing to even consider a psychiatric explanation for their symptoms and as few as 10% will complete the psychiatric referral, it is paramount that the provider gain comfort in addressing these issues. However, by utilizing collaborative stepped care under the auspices of the treating physician, the rates of compliance with psychiatric referral and intervention can be increased. With depression and anxiety exceeding that found in the general population, the physician should develop a greater armamentarium of skills and psychological interventions for

these patients. If the physician continues to find the encounter difficult after organic disease has been adequately evaluated, he should look for a psychiatric cause before additional expensive testing and referrals are initiated.

The doctor should also better understand the characteristics of the doctor-patient encounter. Meeting the patient's expectations and addressing his concerns are the most important factors in determining the level of patient satisfaction. Patients may have unreasonable expectations that interfere with a mutually satisfying relationship. They may also have concerns that their symptoms could represent serious illness that the doctor may fail to understand. There is often a discrepancy between perceived symptom severity and priority between doctors and patients. Patients can be mistreated, avoided, or become dissatisfied because of the physician's frustration. Doctors are frequently disappointed by the patient's failure to understand the energy and effort they expend to address the patient's complaints. In difficult encounters, doctors need to learn techniques to identify patient expectations and negotiate the agenda. They should also understand that they might not get the sense of completion, satisfaction, and reward from difficult relationships. Ultimately, this understanding can contribute to more acceptance of the difficult encounter.

Doctors can use techniques such as "I-statements", mirroring, reflective listening, "feedback sandwich", "What else?", and cognitive behavioral (reframing) techniques. They should hone their skills of empathy and support in order to be an advocate for the patient by acknowledging that the patient's perceived symptoms are real. Doctors should also use their countertransference therapeutically by expressing their feelings in an appropriate manner. They may also focus on the most satisfying and positive attributes of the patient's behavior and personality and use them to provide more satisfaction that both parties require.[24] As Robert Gillette so aptly stated, "You can seldom turn problem patients around completely, but a humane and thoughtful approach to their care can make their lives (and yours!) more comfortable."[25]

APPENDIX A: Suggestions for improved communication (Buzz Phrases)

A. Ways to suggest to patients that there is a link between the physical and the psychological to help them accept a referral to a psychologist or psychiatrist.

--"I truly believe that you are experiencing _____ (pain, tingling...etc) and that it's very uncomfortable and it worries you. I am not saying that your pain is "all in your head" or implying that it's not real in some way. It is. What I am suggesting is that we just consider that there may be a link or connection between what you're feeling in your body and how you're feeling emotionally, your moods, what's going on with the rest of your life."

--Provide specific examples of illnesses that are exacerbated by stress, sadness, and other negative affect*: "We all know that high blood pressure is a real illness, caused by ____ or ____. However, a person's mood, specifically their level of stress or anxiety, has been shown to directly make high blood pressure worse. We see the same thing with headaches, body aches, fibromyalgia, or irritable bowel syndrome that can flare up with stress, anxiety, or depression."*

--Reassure the patient that there is no shame or stigma in exploring other factors in their lives that may be associated with their illness/symptoms. For example, *"Talking things out and getting some things off your chest does NOT mean you are crazy. It's amazing that often just talking out loud to a trained professional can help you to see patterns between things going on in your life and your moods associated with these events, and physical changes or pain in your body. You may be pleasantly surprised when you start to feel better, less bothered, less concerned about your illness, even have the symptom(s) go away to a large extent, by looking at and talking about the "big picture" of your life."*

--Reassure the patient that you will continue to medically monitor them with all appropriate testing and tell them to let you know if symptoms change or worsen.

--If appropriate, ask the patient to consider keeping a diary of symptom exacerbations. Include the following in the entries: what they were doing, thinking, feeling at the time; was symptom presentation preceded by any stress or difficulty, and what they might be able to do, in terms of their mood and coping to make themselves feel better physically (e.g. take a hot shower, exercise...etc.). This last piece may help patients feel they can exert some control over the physical symptoms.

B. Enhancing communication and rapport

"I am finding it difficult to help you because..."

--"How do you feel about it?"

--"Is there anything that can help us work better together?"

C. Setting limits on time and energy-
-- If you are setting limits of time or energy: *"In order to give you the time that you need to best address your problems, I will need to have you come back for a followup appointment next week"*

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