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CHAPTER TWO

Who Are You?

So, who *is* this book about anyway? It is about human beings who are in discomfort and who are seeking relief from this discomfort. Because of past or present events – or a combination of both – they may exhibit certain behaviors which interfere with the efficacy of treatment. Oriental medicine is truly a holistic discipline based on the uniqueness of each individual. In my experience, most of us in this profession cringe at defining or pigeon-holing people. For the purpose of this book, however, a brief definition may be helpful. A survey of existing literature on the subject reveals a surprising lack of definition. Because providers, too, are individuals, there may be conflicting ideas regarding what constitutes a difficult patient. Hooberman and Hooberman offer a concise, broad definition: “A difficult patient is a person who presents to the care-giver behaviors and emotional difficulties of a severity significant enough to impact adversely on the treatment or the provider.”¹

26 Understanding the Difficult Patient

Some of the most common patients you will see who fit this definition are those who are noncompliant, angry, overuse the health care system, are needy, rambling, vague, chronically late, seductive, nonpaying, and/or manipulative. That covers a lot of territory! Each of these particular types will be discussed in their own chapter, and, after some time in practice, you may well be able to add to the list.

In Chapter One, we looked at the practitioner as a potential source of difficulty in the therapeutic relationship. It is essential to keep in mind that when we are dealing with a patient, we are indeed in a relationship with them. As with any relationship, consideration of the other person will allow us to see a different point of view and not take things so personally. Problematic behavior rarely manifests for its own sake. It generally is an outlet of some sort for a deeper issue of which the individual is not fully aware or is unable to cope with. It is helpful for providers to understand the reasons behind troubling behavior. The term “secondary gains” is often used to describe benefits an individual may receive from an illness. This is often the reality in patients who are noncompliant, for example. Secondary gain can be defined as

the use of illness to meet a variety of other needs. This may be the receipt of money for pain and suffering...or the sick role may relieve one of professional and family obligations and may be used to obtain attention and sympathy from others.²

Relief from the illness may force the person to face realities he/she does not necessarily want to face or to assume responsibilities he/she does not want to assume. In addition, some patients may feel they have lost control or independence in their lives, and the resulting frustration can leak out in their behavior. Sometimes, it is just plain old fear that holds someone back from true healing. There may also be personal conflicts, about

which the patient is reluctant to talk and which can affect behavior. Financial woes, a divorce or relationship crisis, problems with children or aging parents, and substance abuse are all examples of existing conditions that a patient may not feel are relevant enough to mention to the practitioner but that, nonetheless, affect the therapeutic relationship and treatment outcomes. Consider the following situations:

Case 1. E. S. is a 19 year-old man with a long history of depression, indigestion and fatigue. Before seeking acupuncture treatments, he had been to numerous doctors and therapists but had found little relief for his symptoms. After treating him for several sessions without results, the acupuncturist suspected that he was resisting getting well. When questioned about this possibility, he at first denied it. On his next visit, though, he opened up, expressing a fear of getting well. He felt that if he did get well, he would have to function in society. Having been out of high school only a short while, he realized he did not know what direction he wanted to go in. His parents had quite high expectations of him and were already disappointed that he was not pursuing a college career. They were very alarmed at his state of health, however, and urged him to seek help before entering college. The acupuncturist allowed this patient to vent his fears and referred him to a psychologist with the understanding that he would work on some of the underlying issues preventing his improvement.

Case 2. R.S. is a woman in her mid-30s who came for help in losing weight. She had initial success in shedding about 20 pounds, was very compliant with diet and exercise instructions, and had a positive attitude. The practitioner was quite surprised when she suddenly did not book her usual weekly appointments, then returned in about a month, having gained most of the weight back. Upon discussing the situation, she revealed that, while she was overweight, she used her weight as an explanation as to why she was unable to find a meaningful relationship. She had con-

28 Understanding the Difficult Patient

vinced herself that if she could lose weight, men would find her attractive and her dating problems would be over. At her lower weight, however, she was still not meeting anyone, and she felt it was easier to gain the weight back and have her old excuse rather than look at some tougher underlying issues.

Case 3. B.W. is a 60 year-old woman who had recently started chemotherapy treatments for cancer. She was hoping acupuncture would alleviate the side effects of her treatment. Each time she came in, she found fault with something the practitioner was doing. The room was too cold, he was talking too fast, the table was uncomfortable, the needles hurt too much, etc. On one or two occasions, she became angry and irritable for no apparent reason, although she was getting satisfactory results from the treatments. The practitioner realized there had to be something else going on, and the next time she came in, he took a few extra minutes to ask how she was doing and what she was feeling. She began to cry and expressed a high level of fear of the unknown and of the initial diagnosis. It was obvious then that her behavior reflected a valid fear that she had not been able to properly express.

Case 4. T.A. is a middle-aged mother of three teenagers who was suffering from severe allergies. She had tried acupuncture before with good results and was anticipating a good outcome this time as well. Her first two sessions went well, but thereafter she cancelled two consecutive visits on very short notice. She did come in again but started asking about fee structure. She told her acupuncturist she was unable to pay the full fee for that visit because she was short on cash and had no checks with her. The acupuncturist also noted at this time that there was an increase in her anxiety level. She took the liberty of asking the patient if she was experiencing any financial difficulties. At that point, the patient revealed a harrowing tale: One of her teenaged sons had been involved in a drunk driving incident which had caused

severe injuries to an innocent party, and the family was now involved in a long *and very expensive* legal battle. When asked why she had not brought any of this up before, she replied, “I didn’t want to unload on you, and I didn’t think this had anything to do with my health or my treatments.” Working together, the practitioner and patient were able to come up with a treatment plan as well as a payment plan that allowed her to continue treatment and devote the energy she needed to her personal situation.

Admittedly, not all covert issues will be so easily revealed by simple discussion. Very often, the patient may not be able to identify or express the depth of the truth. The practitioner needs to hone his/her listening skills because, quite often, a casual remark made during the treatment by the patient may hold clues to their behavior problems.

From the above cases, it is clear to see that most difficult behavior hides fear, anxiety, or some other negative reality the patient is either unaware of or does not want to face. We do not have to be psychologists to help these patients. A little detective work, a sympathetic ear, and a safe place to receive treatment is enough to correct most behavior and improve the patient’s chances for healing. In other cases, the problem may be beyond our scope of practice. If attempts at discussion do not yield positive results or if the patient is just plain unwilling to talk with you, it is most likely time to refer to a psychologist or therapist. It is important from a legal as well as a practical point of view that we as practitioners understand our scope of practice and do not try to be what we are not. Specific situations and suggestions for handling such situations will be dealt with in the following chapters. We would all like to think we can help every single person who comes to us with every single need they have, but this is not the case. So, when in doubt, refer out!

30 Understanding the Difficult Patient

As a final word on attempting to define the problem patient, I would also like to note who is *not* considered a problem patient. For example, cultural differences do not constitute personality problems. When treating a client who is from a different culture, bear in mind that their behavior may be a reflection of the culture and not an indication of difficulty for the practitioner (other than trying to understand the other culture). For example, in many Asian societies, it is unacceptable to complain about pain; stoicism, especially in males, is seen as an asset. It may be difficult to obtain a good history or to ascertain what is wrong with the patient. This type of patient may also not be expressive in telling you when he is experiencing relief.

In many Hispanic cultures, the family unit is placed higher than the individual. It is not unusual for a Hispanic patient to show up in the clinic with two or more family members. Treatment options may be a decision for the whole family to make and not just the patient. There is usually a kind of hierarchy in the family system, with the final decision typically resting with an oldest son or other dominant male figure. There may be much debate and even hesitation during the family discussion.

Traditional Arabic cultures often have very strict rules regarding the treatment of female patients. A traditional female Arab patient will most likely not be comfortable or even permitted to be in a room alone with a man. She may have to be accompanied by a male relative. She may not be able or willing to remove clothing to the degree necessary for treatment.

Diet is a huge issue when considering cultural influences. So much of our teaching in Oriental medicine focuses on diet, but our teaching may not cross cultural boundaries. No matter how high her cholesterol was, my Italian grandmother was not going to give up the fat in her diet for anything and, furthermore, would not have understood the rationale for doing so. I would not want to be the one to tell a Buddhist that she would be better off adding

a little red meat to her diet to nourish the blood. Nor would I relish telling my older Greek gentleman that coffee should be eliminated from his diet.

If there is a language barrier as well, things may get truly complicated. In this case, it is always best to have the client bring along a companion who can translate.

These are just a very few examples of how culture can dictate behavior and, perhaps, hold a challenge for the practitioner. But these patients are *not* being difficult. They are merely acting as their culture dictates. The difficulty here lies simply in the practitioner's ability to broaden his/her horizons and reach beyond what is known and familiar in order to accept the client in the exact place he/she is in.

As professional health care givers, we must also be able to differentiate between a patient with difficult or challenging behavior and the patient who suffers from a true psychiatric disorder, such as schizophrenia or bipolar disorder. Although these patients do pose problems for us, I do not consider them problem patients. They are operating under the influence of an actual disease. Of course, Oriental medicine can treat many psychological and psychiatric disorders, but be sure you are capable and comfortable in treating these cases. Again, there is no shame in referring out if necessary. If you do not have much experience in dealing with these types of disorders, it may be difficult to identify the true psychiatric patient from one who is merely exhibiting difficult behavior. Of course, if the psychological diagnosis is

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32 Understanding the Difficult Patient

what they are coming to see you for, that will make things fairly obvious. But if they are coming for a different problem, the psychological issue may not be so obvious. A review of the medications the patient is taking is very helpful. (You should always have a *Physician's Desk Reference* handy for quick research.) You may want to include some questions on your intake that specifically ask whether the person has experienced or is experiencing any psychological problems, including suicidal ideation. Consulting with a professional in the field of mental diseases is also an option if you feel you need further information on someone's behavior.

Psychiatric or psychological disorders are only one category of diseases that are difficult to treat. In the course of your practice, you will meet many people who have diseases that are very hard to treat or even those that are refractory to Oriental medicine. These cases, too, should not be confused with the patient being difficult. It is the *disease* that is difficult. Frustration, fear of inadequacy, pride, and stubbornness are all pitfalls for the practitioner to be aware of. They can lead you to transfer your own feelings onto the patient, when it is really the condition that is vexing you. In cases like these, honest self-appraisal is the only way out. Consulting with senior acupuncturists or herbalists, doing extensive research, and reviewing the case thoroughly are the tools available to help you deal with the situation and not transfer wrongful traits onto the patient.

A major concept to keep in mind is that the patient is not there for the practitioner. The practitioner is there for the patient. Patients come in all shapes, sizes, and colors. It is your job to understand what makes a person tick, what drives their actions, and what place in life they are coming from. The patient physically comes to you, but otherwise, it is you who must really come to the patient. You are expected to do your best to meet them where they are and to interact with them at their level without compromising the quality of treatment.

QUESTIONS FOR CHAPTER TWO

1. Think of a situation in your own life where you or someone else exhibited behavior that was masking a deeper issue. Were you or they able to resolve the issue? What were the consequences of the behavior?
2. What does the term “secondary gains” mean? Give an example.
3. What are some common underlying issues that may lead to problematic behavior in a patient?
4. Think about the area where you are or plan to be practicing. What are some of the predominant cultures in this area? How might they pose difficulty in a therapeutic setting?
5. Scenario for discussion:
An elderly Japanese gentleman comes to your clinic seeking relief from chronic constipation. He is accompanied by his daughter-in-law. The patient gives very vague answers to questions on the in-take form and seems unduly anxious about the treatments but asks very few questions. His daughter-in-law takes the liberty of asking questions as well as answering questions directed at the patient. On subsequent visits, although objectively he appears more comfortable, he insists that the treatments are not helping him. Use your imagination to construe some possible blocks to this patient’s healing. How would you handle the situation?

Endnotes:

¹ Sohr, Eric MD., *The Difficult Patient*, Medmaster Inc., Miami, 1996, p.47

² Hooberman, R. Ph.D. and Hooberman, B. M.D., *Managing the Difficult Patient*, Psychosocial Press, Madison, 1998, p.8

