



The Difficult Patient: A Psychodynamic Perspective

CRAIG D. WOODS, DDS, MA

ABSTRACT Managing the “difficult” patient is a challenge all dentists face. This paper describes a psychodynamic model that pictures the dentist-patient relationship as a two-way interaction that involves unconscious processes. The model uses the three ego states: the parent, the adult, and the child, to understand problematic encounters and how to manage them. Using this model has the potential to enhance the therapeutic alliance, decrease malpractice claims, and lessen anxiety for the patient and the dentist.

GUEST EDITOR

Craig D. Woods, DDS, MA, is an adjunct associate professor, Oral Medicine and Orofacial Pain, and counselor, Student Affairs Office, University of California, Los Angeles, School of Dentistry.

She stares at me and says, “This still hurts. Is that normal? Shouldn’t I be better by now? Maybe you missed the diagnosis. Certainly you did the wrong treatment. I thought you were supposed to know what you’re doing.” The criticism keeps coming and the attitude gets more sarcastic as I sink into my chair wondering why I’m taking this abuse. I have a vague recollection that I was a confident and competent dentist just five minutes ago. Why do I feel so helpless now?

Most dentists can provide multiple examples of the so-called “difficult” patient. We scan our appointment schedule and cringe at the sight of their names. We visualize the prior interactions and anticipate the worst. There is something about these patients that makes us crazy or, at least, uncomfortable. The first temptation is to blame the patient. They are “rude,” “immature,” “demanding” or any one of many possible negative descriptors. Our

colleagues reassure us that they too have similar problem patients. Even the medical and dental literature supports the view that many patients have problem personalities and chronic behavioral problems.¹⁻⁶ The practitioner’s contribution is ignored.

A more reasonable view posits that the patient does not exist in a vacuum. They are not problematic without our interaction with them. This is not to say the patients are blameless. They are indeed responsible for their behavior in the operator. But it is our reaction that truly characterizes the problematic encounter. Where do we look to understand this sometimes frustrating dynamic?

This paper offers a psychodynamic view of challenging dentist-patient interactions. Dental care consists primarily of a relationship between two adults. Both participants bring a complex personality that was defined from early childhood experience. The resulting encounter is a dynamic process of unconscious and conscious thoughts, emotions, and behaviors. Each participant tries to select

an appropriate behavioral template from their limited repertoire. At best, a relationship of mutual trust and cooperation is developed. At worst, negative personality styles are triggered in both, and a therapeutic situation cannot be realized.

Understanding the internal process enables us to change it to our benefit, or, in the case of interpersonal relationships, to our mutual benefit. In the dental operatory, a fundamental understanding of your and your patient's inner conflicts can greatly enhance your ability to facilitate cooperation and reduce anxiety. Research also strongly suggests that a favorable therapeutic alliance will improve treatment efficacy and lessen malpractice risk.⁷⁻⁹

The Model

Applying the psychodynamic view to the doctor-patient interaction is not a new concept. In an article published in 1956, the renowned psychoanalyst Thomas Szasz coauthored an article, "A Contribution to the Philosophy of Medicine."¹⁰ Szasz and Hollender discussed models of the doctor-patient relationship (TABLE 1). They noted three types of interactions that occur during differing aspects of care. The salient feature is the comparison to family dynamics from childhood.

Guidance-cooperation involves much of medical and dental practice. The patient seeks help and is willing to obediently follow the directives of the doctor. The interaction of a parent and a child is similar in that the parent is the source of knowledge and power while the child is forced by social custom to adhere to parental demands. The unequal power lends itself to efforts at manipulation or defiance, even child-like acting out by the patient. Szasz also pointed out the opportunity for "exploitation" on the part of the physician. The physician or

TABLE 1

Three Basic Models of the Physician-Patient Relationship (from Szasz and Hollender⁷)

Model	Physician's Role	Patient's Role	Clinical Application of Model	Prototype of Model
Activity-passivity	Does something to patient	Recipient (unable to respond or inert)	Anesthesia, acute trauma, coma, delirium, etc.	Parent-infant
Guidance-cooperation	Tells patient what to do	Cooperator (obeys)	Acute infectious processes, etc.	Parent-child (adolescent)
Mutual participation	Helps patient to help himself	Participant in "partnership" (uses expert help)	Most chronic illnesses, psychoanalysis, etc.	Adult-adult

TABLE 2

Three Basic Models of the Dentist-Patient Interaction (from Freeman⁸)

Model	Dentist's Role	Patient's Role	Clinical Application of Model	Prototype of Model
Activity-passivity	Does something to patient	Receives the treatment	Operative dental treatment	Parent to child
Guidance-cooperation	Tells patient what to do	Obeys accordingly	Dental check-up appointment	Parent to child
Mutual participation	Advises and negotiates with patient	Patient in equal partner care	Negotiation of treatment or preventive plans	Adult to adult

dentist may use authoritarian strategies to overwhelm the patient's defenses. The task may get accomplished, but there will likely be lingering resentments.

The mutual participation model suggests that, at times, the patient and doctor can come together as equals. This can happen if both are willing to share power; they realize they need each other (interdependence), and the result can be satisfactory to both. This represents a patient and doctor who each possess the coping skills necessary to work through their anxieties

and enter into a working relationship.

Ruth Freeman applied the Szasz and Hollender model to the dentist-patient interaction utilizing parent-adult-child ego states from "transactional analysis" to describe common interactions.¹¹ For example, Freeman likened the dentist performing an operative dentistry procedure on a patient (TABLE 2) to the patient unconsciously seeing the dentist as a parental figure and regressing into a child ego state.

Transactional analysis divides the

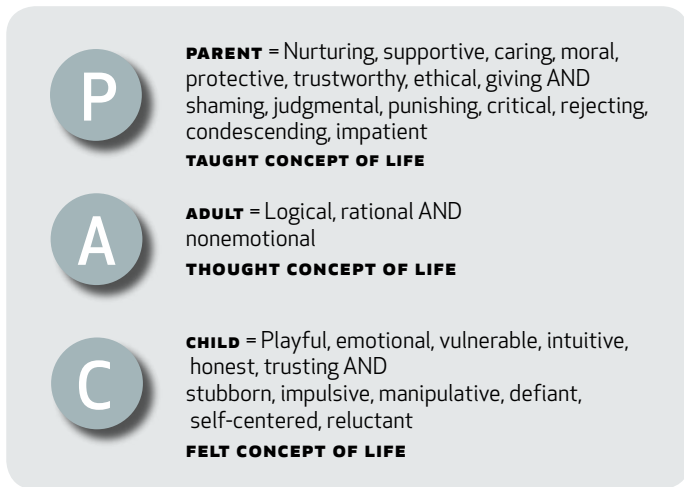


FIGURE 1. Ego states

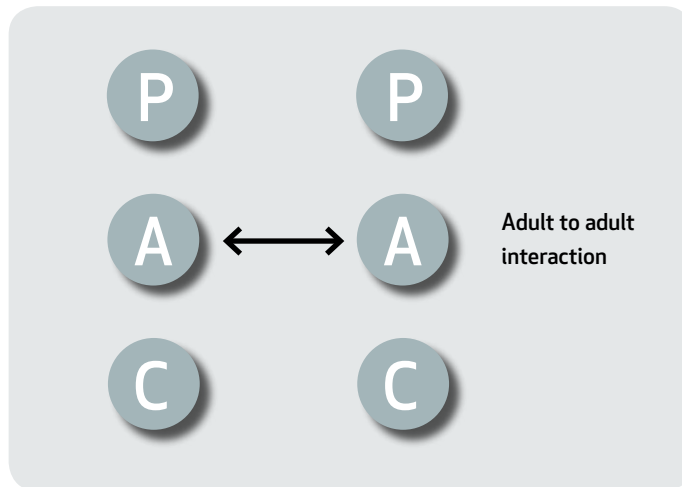


FIGURE 2. Mutual participation

personality into three parts: the adult, the parent, and the child (FIGURE 1).^{12,13} In this view, the “child ego state” develops as part of the personality from birth to age five. Much is established even before language is developed (pre-verbal stage). The child observes his or her environment, primarily his caregivers, and struggles to survive. The infant first needs to know if he can trust the all-powerful caregiver. The stakes (sustenance or abandonment) are high and the emotions strong.

The child develops many characteristics that may remain within us into adulthood. The positive side is that the child is loving, open, giving, playful, spontaneous, persevering, adaptive, and creative.¹⁴ This is the part of the patient that laughs at dumb jokes and enthusiastically discusses his recent vacation. On the other side, the inner child is stubborn, greedy, dishonest, impulsive, manipulative, defiant, narcissistic, and unpredictable. Your patient can be angry at you with a slight provocation or refuse to take responsibility for his own dental health.

The “adult ego state” is our rational, problem-solving mind. We acquire experience and create workable mental constructs. This process is ongoing as one practices life skills in new situations. The adult is logical, nonemotional, purposeful, intellectual, and deliberate.

The “parent ego state” is an accumulation of imposed rules, dictates, morals, and behaviors acquired in the earliest years, typically from primary caregivers. One can think of this as the “shoulds” (you should be a good boy, etc.). On the better side, the parent is nurturing, supportive, caring, protective, ethical, respectful, trustworthy, warm, and giving. Dentists all have patients who genuinely care about us and our families. They truly wish for our success and happiness. Unfortunately, the critical parent side can also be shaming, rigid, judgmental, punishing, overbearing, and controlling. This is the patient described in the opening paragraph of this paper. In the example, the patient wishes to punish the doctor for her discomfort by being harshly critical. The doctor responds by entering the child ego state.

The goal in one’s dental operatory, as suggested in the mutual participation model (FIGURE 2), is that the dentist and patient engage while in their adult ego states. Unfortunately, anxiety often intervenes. For the patient there is the acute and realistic fear of pain. Unconsciously, one can experience a loss of control, violation of personal space, or something else. An interesting phenomenon that commonly occurs in the dental operatory is a process well described by Freud. He ob-

served that patients would transfer feelings and attributes of significant figures in their lives onto him. He called this phenomenon “transference” and it became a very important aspect of psychoanalysis. Often, these figures were parents or other authority figures and at these times, the patient would assume the characteristics of a child. Freud termed this “regression.”

The Model in Action

In the dental operatory is a situation that is ripe for transference and regression (FIGURE 3). The patient feels anxious, vulnerable, and not in control while the dentist is the powerful, knowledgeable, and imposing authority figure. Using the model of ego states, the patient regresses into her child state and sees the dentist as a parent. The dentist may choose to exploit this power in order to complete the proposed treatment. The patient may comply but not without some emotional expense. In other cases, the child may rebel. This can be seen in cancelled appointments, late payments, or manipulative behavior.

Early recognition of regression can prevent a poor outcome. The patient may be subtly uncooperative in the chair. Simple displays such as fidgeting or squirming, a change in voice pitch, and looking away in a submissive way can be indicative of the child coming out. More

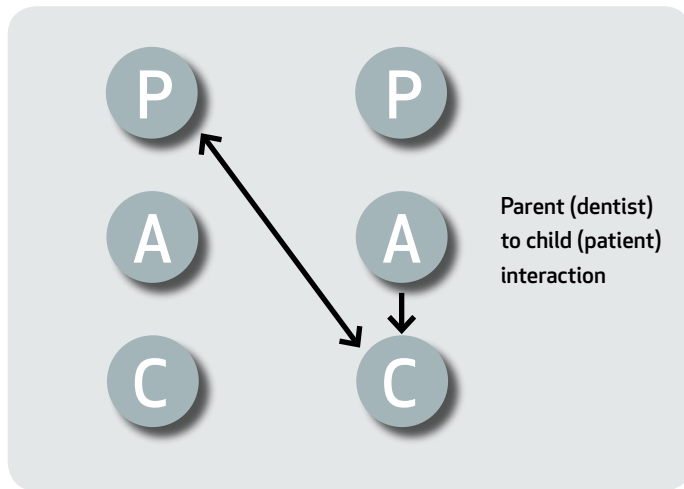


FIGURE 3. Transference and regression (parent to child)

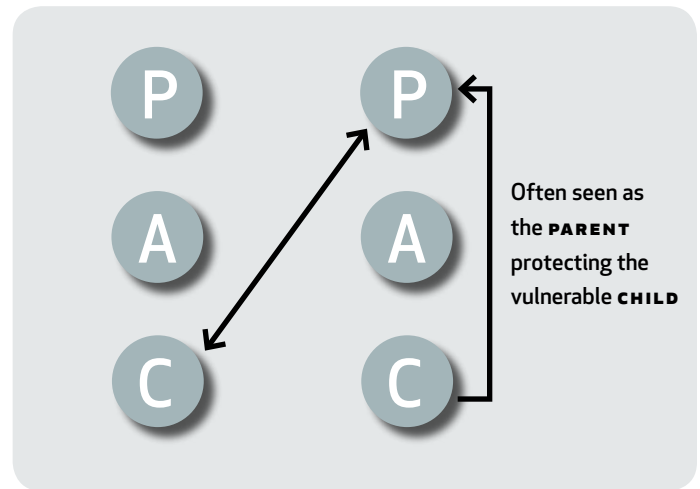


FIGURE 4. Patient as the parent (child to parent)

overt child-like behavior includes whining, crying, inappropriate statements, or outright defiance. Once recognized, the behavior can be addressed by the doctor.

A child desires comfort from a loving parent. The goal is to establish trust with the child, which will allow the patient to return to the adult ego state. The general rule in relationships is that you can only gain someone's trust by appealing to their inner child. This is a good time for dentists to remember the skills learned for pediatric dentistry. Dentists need to give explanations of everything they do in straightforward terms (remember tell-show-do?). Immediately praise the patient for each new instance of cooperative behavior, "You're doing great." Intermittently praise an already established positive behavior. Ignore uncooperative behavior and attempt to distract the patient away from it. Give choices whenever possible in order to give the patient a sense of greater control, "You can raise your left hand if you feel anything and I'll stop immediately." Acknowledge their feelings. State it is OK to feel nervous or anxious about the procedure. Use socially acceptable touch to comfort and reassure your patient. This can be done simply with a hand on the shoulder.

Once the child is comforted and feels secure, one will be able to speak to the

adult. That is, it is now appropriate to deal with the rational and thinking part of the patient. Explanations can become more abstract. For instance, one may discuss long-term prognosis, treatment options, and postoperative care. One should ask about their understanding of your advice ("Am I making sense?" "What can I clarify for you?"). Listen carefully and restate back to the patient what you believe they said. ("It sounds like you would like the implant but you are concerned about the surgical part.")

Regularly update the patient on the status of the progress, "I'm 80 percent done and all is going smoothly." Even adults do not do well with the unknown. One can also ask about their feelings in order to gauge their management of their emotional state ("How are you doing?" "Are you comfortable?"). Even though your patient's adult state is now in charge it is a good idea to maintain a good relationship with your patient's child state. The author's personal favorite is to use humor. Humor is a tried and true, healthy coping mechanism for anxiety. Benign jokes, puns, and other plays on words will keep the inner child amused thus keeping his or her trust in the dentist.

Also, an adult will be capable of understanding a sincere apology. If a procedure takes too long or the dentist inadvertently

hurts the patient, then an immediate, brief apology is in order. Don't dwell on it, just state your case and back to business.

On occasion, the patient's child may feel threatened to the degree that the inner parent is called in to protect him (FIGURE 4). The powerful, judgmental, and punitive parent will attempt to intimidate the doctor into a submissive position. The doctor who is in her confident adult state will not wilt. But if the child within the dentist connects back to her own family of origin then, she may assume a child-like role. This process, in which the doctor unconsciously responds to the patient's influence, is known as "countertransference." It was described by Freud as far back as 1910. Casement, a renowned psychoanalyst, stated that countertransference occurs "when a patient comes to represent some unresolved aspect of a significant relationship in the earlier life of the analyst or therapist; and this will threaten therapeutic work with that patient unless it is resolved through further self-analysis of the therapist."¹⁵ In other words, one's childhood issues may negatively impact the working relationship.

The parent ego state can be discerned through the patient's behavior. There may be condescending looks, crossed arms, a furrowed brow, sighing, and shaking of the head. The tone of voice may change

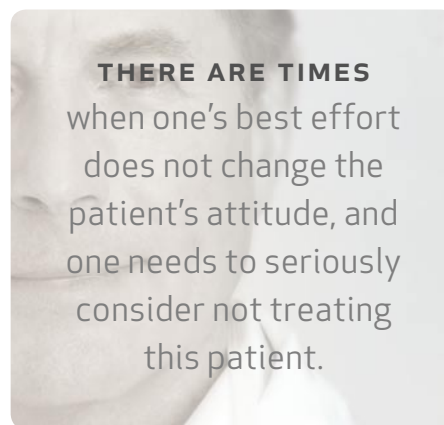
to become sterner. One may hear evaluative words (often critical), many “shoulds” and “oughts,” and words that demonstrate black-and-white thinking such as “always,” “never,” and “all.” There may be direct attempts to diminish the dentist by calling them diminutive names like “Doc.” Now is the time to stay firm in your adult ego state. Becoming another critical parent will lead to a battle that cannot be won.

Managing your patient’s critical parent is similar to managing the angry patient.¹⁶ First, one needs to be seated at eye level with him. This conveys the idea that the dentist will be speaking as an equal. Lower one’s voice to a calm, firm tone, and speak slowly and clearly. This says, “I will not back down but I won’t fight you either.” Eliminate all humor, as you are thinking “You and I will be serious until this issue is resolved.” Listen carefully to what the patient says because the dentist must individually address each concern. Repeat it back so that both sides agree on the points of concern. Use the person’s name when speaking, since this is what their adult ego state identifies with. As one makes one’s points, remember, the dentist is not arguing. The dentist is stating their side as objectively as possible. Use “I” statements; that is, taking ownership of one’s side of the story while not blaming or labeling the patient’s behavior. Ultimately, one can expect the physical signs of the parent ego state to fall away, the tone of the patient’s voice will change, and he will become cooperative again.

There are times when one’s best effort does not change the patient’s attitude, and one needs to seriously consider not treating this patient. Perhaps there are unconscious influences on one or both sides that cannot coexist. There is no blame to be placed. An offer to refer the patient to a respected colleague may be the best solution.

Scenario 1

Mrs. Adams presented with pain a week after a routine restorative procedure. Her muscles were tense and she stated indignantly, “My tooth still hurts. Is that normal? I’ve never had this happen before.” Her critical and condescending parent is paying a visit to set the dentist straight and to protect her hurt, and possibly mistrustful child. Her behavioral template from childhood tells her that a critical parent will



quickly get a child to behave in a better manner. Unfortunately, she is not consciously aware of this, and has yet to realize that templates from childhood often do not work in the adult world.

The doctor now has to choose a behavioral template in response. A poor choice would be to match her critical parent with his own inner critical parent. The author calls this the “soccer game” scenario: two angry parents trying to protect their own child. These confrontations appear in the newspaper the day after a physical battle. If the dentist is young and lacking in confidence, he may accept that he was bad and deserving of a reprimand. He submissively (sad-faced, pouting) solves the acute problem (redoes with work

“with attitude”) but may lose the respect of the patient. He also will suffer from future anxiety when this patient or similar patients are on his schedule.

The best choice is to stay as the adult. The adult will stay out the emotional trap but realize he is dealing with a hurt child. The first step is to get the patient from parent to adult or child. In a seated position, at eye level, the dentist talks slowly and clearly while frequently using the patient’s name (this is what the adult responds to). He will not argue (that’s critical parent to parent) and he will not use humor (the child is not available to enjoy it yet). He will mentally reassure his own child he will handle the situation and that this angry and mean lady will not be allowed to abuse him. He will listen intently to her complaints and help her to explore her concerns (not just the pain, but needing to miss work to come in or the fear this will mean an additional procedure she might not be able to afford). He will repeat back to the patient what he heard and understood from her. It may take a few times to get this right.

At last, the patient feels understood and the critical parent is no longer needed. The dentist immediately notices the physical response. The patient is relaxed and the tone of voice changes. The person sitting in the chair is now the rational adult. Finally, it is appropriate to logically explain the diagnosis and treatment. Also, the child will now be available. The doctor can use his nurturing parent to soothe the child by smiling, placing a hand on her shoulder, and using gentle humor. The patient will now be cooperative but, more importantly, the dentist knows he has the tools to manage a “difficult” patient. There may be less anxiety the next time he sees another one on his schedule.

Scenario 2

Dr. Whiting is having a tough day. His production for the month is down, an implant patient cancelled this morning, and he had to send a crown back to the lab. Playing in his head is his nagging, critical parent telling him how incompetent he is and how no other dentist has all the problems he does. Now, Mr. Sanders arrives for a crown prep but he questions the doctor, "Do I REALLY need this?" "Of course you need this," Dr. Whiting's critical parent answers. The procedure is accomplished in silence as the patient is passively uncooperative. Mr. Sanders is in his noncompliant child state and Dr. Whiting remains in his critical parent state. Later that day, the patient wonders if he should ever trust this dentist again while the dentist feels guilty about the shabby way he treated a nice patient. This episode would have been so much different if Dr. Whiting dealt with his own childhood issues. Using his nurturing parent, he could reassure his hurt child that everyone has a bad day and he's still a good dentist and person. Then he would have been able to comfort the patient's child when he saw the patient's initial attitude to treatment. After insuring the child's trust, the procedure would go smoothly with both participants grateful to the other.

Summary

There are an infinite number of possible dentist-patient interactions. Using a simple, three ego state model can simplify troublesome dynamics and suggest a course of action. Although we cannot change the patient's psychological makeup, we can manage it better. On the other side, we can change our attitudes and behaviors. We can become aware of the situations that arouse our inner child or parent. Observing our emotional response to a patient (getting

in touch with the child) is the first step. Then we need to be aware of the ego state (with its corresponding behavioral template) we choose. If we repeatedly utilize dysfunctional responses, then we are likely to experience anxiety and poor interactions with some of our patients. Exploring our own issues (e.g. the need to be liked, the need to be in control, etc.) may be in order. The resulting changes in our approach can enhance treatment and increase our satisfaction as caregivers. ■■■■

REFERENCES

1. Groves JE, Taking care of the hateful patient. *N Engl J Med* 298(16):883-7, April 20, 1978.
2. Freeman R, A psychodynamic understanding of the dentist-patient relationship. *Br Dent J* 186(10):503-6, May 22, 1999.
3. Steinmetz D, Tabenkin H, The "difficult patient" as perceived by family physicians. *Fam Pract* 18(5):495-500, 2001.
4. Gamer S, Tuch R, Garcia LT, MM House mental classification revisited: Intersection of particular patient types and particular dentist's needs. *J Prosthet Dent* (89)3:297-302, March 2003.
5. Centore L, Reisner L, Pettingill, CA, Better understanding your patient from a psychological perspective: Early identification of problem behaviors affecting the dental office. *J Calif Dent Assoc* 30(7):512-9, July 2002
6. Christensen GJ, Treating the potential problem patient. *J Am Dent Assoc* 132(11):1591-3, November 2001.
7. Seoane J, Varela-Centelles P, et al, Concordance between undergraduate dental students and their lecturers in their attitudes toward difficult patients. *Eur J Dent Educ* 6:141-6, 2002.
8. Krupnick JL, Sotsky SM, et al, The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *J Consult Clin Psychol* 64:532-9, 1996.
9. Forster HP, Schwartz J, DeRenzo E, Reducing legal risk by practicing patient-centered medicine. *Arch Int Med* 162:1217-9, 2002.
10. Levinson W, Roter DL, et al, Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. *JAMA* 277(7):553-9, 1997.
11. Szasz TS, Hollender MH, A contribution to the philosophy of medicine: The basic models of the doctor-patient relationship. *AMA Arch Intern Med* 97(5):585-92, May 1956.
12. Freeman R, A psychodynamic understanding of the dentist-patient relationship. *Br Dent J* 186 (10):503-6, May 22, 1999.
13. Berne E, Games people play: The psychology of human relationships. Grove Press, Inc., New York, 1964.
14. Harris TA, I'm OK - You're OK: A practical guide to transactional analysis. Harper & Row, New York, 1967.
15. Subby, R, Healing the family within. Deerfield Beach (FL): Health Communications Inc., 116, 1990.
15. Casement PJ, Learning from the patient. The Guildford Press, New York, 80, 1991.
16. Johnson SL, Therapist's guide to clinical intervention. Academic Press, second edition, New York, 295, 2004.

TO REQUEST A PRINTED COPY OF THIS ARTICLE, PLEASE CONTACT Craig D. Woods, DDS, MA, University of California, Los Angeles, School of Dentistry, Box 951668, Los Angeles, Calif. 90095-1668.