The heart sink patient revisited by C. Butler BJGP, March 1999.

- O'Dowd in 1989 described 'heart-sink' patients
- The problem is serious: median of 6 per dr.; & 2-3 x higher rates of referral & investigation. Time & economic problem.
- Features of pt: psychopathology, psychosomatic illness, depression, lower socio-economic class, being female, thick folders, being older, more acute & chronic medical problems
- Features of doctors: inexperience, greater perceived workload, lower job satisfaction, lack of post-grad qualifications, lack of training in communication skills.
- One dr's set of heart-sinks is not the same as another's. (Gerrard & Riddell)
- The heart-sink is ?product of an ineffective doc-pt communication
- Not united only by response they produce in dr: Good says they are united in looking at medicine as a salvation (soteriological terms= pertaining to salvation). In Good's terms, medicine influences, suggests, or in some cases, wholly supplies the character & identity of some individual's personal suffering, & is the apparent source of their 'salvation' or redemption.
- Conflict: pt looking for salvation/ doctor in bio-medical model looking to identify & cure disease- not life's ills. Difficulty is compounded by evidence-based med & its fixation on biological models & biomed solutions.

Management
- Improve dr's self-awareness, counselling & consultation skills
- Magical technique/ flash technique (Balint):-resonant of priest in confession booth-respond only to what pt is saying; do not try to penetrate defences & pin-pt the root of the problem. Listening to the patient can be therapeutic for the pt.
- 'Holding strategy': do not attempt to bring about change; listen to the pt without contradicting him, thus providing a safety valve.
- Improve dr's working conditions to reduce stress- helps them to cope better with demanding problems.
- Enhance understanding of pt & share responsibility for pt by team discussion. This is time-consuming.

Conclusion:
- The soteriological must be recognised, & therefore the heart-sink presents with genuinely medical & not pseudomedical problems.

Heart Sink Patients

What makes a Heart Sink: **The dysfunctional Dr/Patient relationship**

Is there a problem with me? **The Sheffield paper**: suggests that Drs with poor Job satisfaction, high-perceived workload, lacking in appropriate post-grad Qualifications and in counselling & communication skills had higher numbers Of heartsink patients.

Is there a problem with the patient: Present repeatedly, often with trivial symptoms, in an inappropriate pattern of health seeking behaviour.

Model of games playing: **Victim Rescuer Persecutor**
Patient presents as victim with symptoms, Dr becomes rescuer by trying to sort out he problem, Patient by repeated similar presentation, deviation from Rx plan etc becomes Dr's persecutor, infuriated Dr refuses to see patient in future, or exaggerated negative response makes them become the patients persecutor.

Management

- Doctor as drug: the consultation is viewed by patient as the treatment
- Listen carefully to the patient's story: could they actually have
- Pathology, are there any clues as to what is at the heart of their odd
- Behaviour?
- Support their ego in resolution of their own problems.

TYPES OF DIFFICULT PATIENTS

The "difficult patient" may be divided into **four types:**

a. The patient who rejects help
b. The patient who demands help
c. The patient who manipulates help
d. The patient who is beyond help

a. The Patient Who Rejects Help

This group of patients has been described as Manipulative Help-Rejecters'. They will return again and again to the doctor to complain that treatment does not work and tend to play the "Why don't you.... Yes but..." game". Their objective of the consultation is to seek attention rather than relief of symptoms and this tends to provoke frustration in the doctor.

b. The Patient Who Demands Help

Another description of such a patient is "entitled demander"'. They try to control the doctor through the use of intimidation, devaluation and guilt induction. This is a reflection of fear and insecurity in the patient. In Transactional Analysis terms, such patients often draws the doctor into the game, "NIGYSOB" or "Now I've Got You, Son Of a Bitch"'. The end result is the evocation of guilt and anxiety in the doctor.

c. The Patient Who Manipulates Help

These are the "dependent clingers" who tend to make repeated requests for all forms of attention.

They have inexhaustible need for love and attention and provoke aversion and resentment in the doctor. The game which they may play is "Poor Me."'

d. The Patient Who Is Beyond Help

Such a patient has been called a "self destructive denier".' Their behaviour is often a chronic form of suicide as exemplified by the incurable alcoholic or non-compliant diabetic. These patients have given up hope of having their dependency needs met and resist treatment. It is therefore not surprising that they tend to provoke rejection in the doctor. The game transaction which they tend to be involved in is "Kick Me."'

Helping the Patient (from Annals of Internal Medicine; American College of Physicians Volume 130(11) 1 June 1999 pp 910-921
Functional Somatic Syndromes [Review] Barsky, Arthur J. MD; Borus, Jonathan F.

The hyperbole, litigation, compensation, and self-interested advocacy surrounding the functional somatic syndromes can exacerbate and perpetuate symptoms, heighten ears and concerns, prolong disability, and reinforce the sick role. Excessive medical testing and treatment expose patients to iatrogenic harm and amplify symptoms. Exclusive emphasis on a search for structural abnormalities can distract physicians from eliciting the patient's beliefs, expectations, and personal circumstances.
Patients with functional somatic syndromes can become so engrossed in establishing the legitimacy of their condition, so invested in discovering the cause of their symptoms, and so preoccupied with assigning fault and culpability that palliative treatment is made more difficult or is forgone.

Given these caveats, how should clinicians proceed?
Medical management rests on six steps:

1) Ruling out the presence of diagnosable medical disease,
2) Searching for psychiatric disorders,
3) Building a collaborative alliance with the patient,
4) Making restoration of function the goal of treatment,
5) Providing limited reassurance, and
6) Prescribing cognitive-behavioural therapy for patients who have not responded to the aforementioned five steps.

First, clinicians must uphold their medical mandate with an appropriate search for a previously unrecognised medical disorder.
In deciding how extensive this medical work-up should be, physicians must remember the adverse effects of overly aggressive investigation, of fostering the sick role, and of leading patients to expect a definitive medical explanation for all somatic distress. Caution is advised in ordering tests and obtaining specialty consultations solely to reassure the patient-negative findings provide little reassurance to most patients with chronic, medically unexplained symptoms and often ultimately heighten rather than assuage worry and anxiety. Furthermore, extensive medical testing carries the risk for iatrogenesis and solidifies the patient's conviction that his or her distress has a biomedical cause. It is therefore helpful to have evidence-based guidelines for the appropriate extent of medical evaluation and the frequency with which such evaluation should be repeated.
Currently, expert consensus has been promulgated for only a few functional somatic syndromes.

Second, the physician should search for diagnosable psychiatric disorders, particularly major depression and panic disorder (which are highly prevalent and treatable). Self-report screening questionnaires and brief, structural diagnostic interviews can assist the physician in this search. It is important to remember that the likelihood of a psychiatric diagnosis increases linearly with the number of somatic symptoms that the patient reports. For example, compared with patients who have no pain, those who have medically unexplained pain at two sites have a fivefold higher prevalence of major depression, and those with three or more pains have eight times the risk for major depression. The stigma associated with a psychiatric diagnosis often makes patients feel that the legitimacy of their illness is being discounted and may make them cling more assiduously to a biomedical explanation of their symptoms. Patients must be assured that the presence of a psychiatric disorder in no way means that their somatic symptoms are imaginary or feigned. They should be told that psychiatric disorders are regarded less as causes of somatic symptoms than as amplifiers that exacerbate and perpetuate symptoms and impede recovery.

Third, a collaborative therapeutic alliance between physician and patient is crucial. The physician must take special care to acknowledge and legitimise the patient's suffering because a definitive biomedical explanation for the patient's symptoms has proven elusive. At the same time, the physician should discourage the patient from assuming the sick role, should undercut alarming expectations about the clinical course, and should avoid making distressing symptom attributions. Closely related to the establishment of a collaborative alliance is the process of making symptom palliation, coping, and rehabilitation the focus of the clinical enterprise. The goal of treatment becomes the identification and alleviation of factors that amplify and perpetuate the patient's symptoms and cause functional impairment. The focus is on coping rather than on curing, on improving functional status rather than eradicating symptoms. If this is to be accomplished, patients with functional somatic syndromes must be actively involved in the treatment process and must be dissuaded from assuming a passive role and waiting to be cured by medical procedures or interventions. Realistic, incremental goals should be set and should be specified in terms of observable behaviours. (For example, a gently graduated exercise program should be prescribed.) Patients should be encouraged to resume their activities as much as possible and to remain at work if they are at all able.

Limited, cautious reassurance is appropriate. Patients can be reassured that grave medical diagnoses have been ruled out and can be told clearly that they do not have a lethal or progressive disease. However, because these patients feel ill and symptomatic, it is not enough to tell them what they do not have without telling them what they do have. It is often helpful to describe the process of amplification, whereby sociocultural and psychological processes exacerbate distress and hinder recovery. Although it does not provide a definitive etiologic explanation for a patient's distress, such a discussion gives patients an explanatory model that focuses on processes and functioning rather than on structural abnormalities.

Finally, if these strategies are insufficient, cognitive-behavioural therapies can be effective in treating the persistent distress and disability resulting from functional somatic syndromes. Such therapies have been developed for the somatoform disorders and for some medically unexplained symptoms, including those of the irritable bowel

syndrome, fibromyalgia, the chronic fatigue syndrome, headache, and atypical chest pain. Controlled intervention trials with long-term follow-up have shown the effectiveness of cognitive-behavioural treatment in reducing somatic symptoms, generalized distress, and disability. These interventions help patients cope with symptoms by helping them reexamine their health beliefs and expectations and explore the effects of the sick role and of stress and distress on their symptoms. They help patients find alternative explanations for symptoms, restructure faulty disease beliefs, alter expectations, and learn techniques of focused attention and distraction. Behavioural strategies, such as response prevention, systematic desensitisation, graduated exercise regimens, and progressive muscle relaxation, help those with functional somatic syndromes resume normal activities, minimize role impairment, and curtail sick role behaviours. The cognitive-behavioural approach stimulates patients to assume a more active role in coping and rehabilitation, and it counters the assumption that cure results only from the application of technological interventions to passive patients.

The role of traditional psychotherapy is generally restricted to cases in which the patient with a functional somatic syndrome identifies a psychological problem or a source of emotional distress for which he or she wants treatment. Psychotropic medications are indicated when a pharmacologically responsive psychiatric disorder (such as major depression or panic disorder) is present. In addition, antidepressants sometimes alleviate somatic symptoms (particularly pain and insomnia) and may improve the functional status of patients who have functional somatic syndromes and sub threshold psychiatric disorders.
The empirical evidence for the efficacy of antidepressants is strongest for the chronic fatigue syndrome, fibromyalgia, and the irritable bowel syndrome. Little is known about the use of alternative therapies in functional somatic syndromes. They may help some patients by providing an enhanced sense of self-efficacy and control over symptoms, but empirical data on this topic are not available.

To look at **Pennebaker's** work in this field, see
http://homepage.psy.utexas.edu/homepage/faculty/pennebaker/reprints/.