Patient Embitterment: The Hidden Barrier in Clinical Care Transcript

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Introduction and speaker background

Hi everyone. Um, thanks to the academy. Hi everyone. Um, thanks to the academy. My name is Javier Jimenez. I'm the My name is Javier Jimenez. I'm the director of CL Psychiatry at Long Island director of CL Psychiatry at Long Island Jewish Medical Center, part of Northwell Jewish Medical Center, part of Northwell Health. Um, I'm going to be speaking Health. Um, I'm going to be speaking about something very related actually to about something very related actually to what has already been presented on. So, what has already been presented on. So, it's a nice segue. um a a concept uh it's a nice segue. um a a concept uh post-traumatic embitterment that is not post-traumatic embitterment that is not um necessarily part of our lexicon maybe um necessarily part of our lexicon maybe yet. Uh and I think it's helpful for us yet. Uh and I think it's helpful for us um when we're conceptualizing the um when we're conceptualizing the so-called difficult patient which still so-called difficult patient which still is in our lexicon unfortunately. Um I is in our lexicon unfortunately.

Post-traumatic embitterment overview

Um I have no disclosures related to this have no disclosures related to this work. Um you might have seen another work. Um you might have seen another name on there under under mine. That's name on there under under mine. That's Dr. Chernish. Just go back for one Dr. Chernish. Just go back for one second. I'm indebted to her. She's second. I'm indebted to her. She's actually a former CL fellow in our actually a former CL fellow in our program who is now an attending in program who is now an attending in Connecticut and she brought this concept Connecticut and she brought this concept to my attention when we were working to my attention when we were working clinically and I'll unpack it in a clinically and I'll unpack it in a second. So um again to set the table we second. So um again to set the table we are tasked with some challenging are tasked with some challenging situations in our line of work. It's no situations in our line of work. It's no surprise actually 10 years ago I surprise actually 10 years ago I remember doing a pre-conference workshop remember doing a pre-conference workshop at the academy with a number of other at the academy with a number of other speakers on the difficult patient and it speakers on the difficult patient and it was a 4-hour session talking about all was a 4-hour session talking about all the different psychotherrapeutic the different psychotherrapeutic modalities and diagnoses and all of modalities and diagnoses and all of that. Today I'm going to just focus on that. Today I'm going to just focus on on one element that might be at play in on one element that might be at play in the so-called difficult patient. Um much the so-called difficult patient. Um much of the attention has been sort of of the attention has been sort of directed at personality traits uh directed at personality traits uh disorders, diagnoses, DSM categories, disorders, diagnoses, DSM categories, things like that. And then of course things like that.

Clinical cases of embittered patients

And then of course other frameworks like counter other frameworks like counter transference, um of course other transference, um of course other diagnoses. I'm not going to focus on diagnoses. I'm not going to focus on that. The alternative view that I'm that. The alternative view that I'm going to talk about today is not mine.

going to talk about today is not mine. It's something that um is is borrowed It's something that um is is borrowed from other scholars actually from the from other scholars actually from the old world in Europe. Um the idea that old world in Europe. Um the idea that somebody may have longlasting somebody may have longlasting embitterment which we'll unpack um embitterment which we'll unpack um secondary to either medical trauma or secondary to either medical trauma or some other insult and that that is some other insult and that that is informing to a large part the so-called informing to a large part the so-called difficult behavior or um um you know difficult behavior or um um you know experiences that were encountered. So experiences that were encountered. So one definition of embitterment is that one definition of embitterment is that this important feeling um sorry the this important feeling um sorry the definition is coming up but leading this definition is coming up but leading this all led to this development of a all led to this development of a diagnostic construct not in the DSM of diagnostic construct not in the DSM of PTED we'll talk about so what is PTED we'll talk about so what is embitterment embitterment refers to

of embitterment embitterment refers to of course this difficult angry um state um course this difficult angry um state um individuals may present phenotypically individuals may present phenotypically like we were just describing refusing like we were just describing refusing help u communicating frustration help u communicating frustration hostility anger it can even of course uh hostility anger it can even of course uh feature suicidality, homicidality or at feature suicidality, homicidality or at least the expressions of that the common least the expressions of that the common theme described here is a loss of theme described here is a loss of something right some deep injustice that something right some deep injustice that has led to this um and that's important has led to this um and that's important for us as seal psychiatrists I would for us as seal psychiatrists I would argue to identify in given patients argue to identify in given patients this uh phenomenon psychological this uh phenomenon psychological construct whatever you want to describe construct whatever you want to describe has been uh seen in a number of has been uh seen in a number of populations not just medical um populations not just medical um immigrant populations that have lost immigrant populations that have lost much. Um it's been studied formally in much. Um it's been studied formally in different ones. I have references for different ones. I have references for those who are interested. Um those who are interested. Um the adolescent certain actual DSM diagnoses.

adolescent certain actual DSM diagnoses. So you can see how it's being looked at So you can see how it's being looked at across clinical and nonclinical across clinical and nonclinical populations. And even in the medical populations. And even in the medical setting, we're we're starting to see setting, we're we're starting to see literature describing this in certain u literature describing this in certain u diseases that that we of course treat.

diseases that that we of course treat. I'm not going to read them all there, I'm not going to read them all there, but um medically unexplained symptoms, but um medically unexplained symptoms, etc.

etc. etc. I want to share two clinical vignettes. I want to share two clinical vignettes. These are real cases that my fellow and These are real cases that my fellow and I had um seen. One on the outpatient I had um seen. One on the outpatient side in an ambulatory CL space and then side in an ambulatory CL space and then one in the inpatient side. It's it's a one in the inpatient side. It's it's a lot to read, but I think it's important lot to read, but I think it's important for us to just quickly get through it.

for us to just quickly get through it. The first case is a 55-year-old woman The first case is a 55-year-old woman with past medical history of intractable with past medical history of intractable focal left epilepsy 10 years in duration focal left epilepsy 10 years in duration referred to us by neurology. They were referred to us by neurology. They were recommending surgical intervention that recommending surgical intervention that she kept delaying. Uh neurology she kept delaying. Uh neurology characterized her as difficult at times, characterized her as difficult at times, strong personality and she initially strong personality and she initially presented as very pleasant, cognitively presented as very pleasant, cognitively intact though quickly transitioned into intact though quickly transitioned into this very loud agitated demeanor while this very loud agitated demeanor while discussing her experience with her discussing her experience with her illness. uh she became intermittently illness. uh she became intermittently pressured in speech that though she was pressured in speech that though she was always interruptible and she noted that always interruptible and she noted that seizures significantly affected her life seizures significantly affected her life losing her fulfilling job as a teacher losing her fulfilling job as a teacher and her abilities to drive and advocate and her abilities to drive and advocate for herself. She felt very resentful for herself. She felt very resentful towards family and friends, providers towards family and friends, providers and healthcare at large. So this very and healthcare at large. So this very diffuse sort of resentment uh feeling diffuse sort of resentment uh feeling misunderstood and even exploited. She misunderstood and even exploited. She added that she was actually abused um added that she was actually abused um after having a seizure in public which after having a seizure in public which led to uh some agorophobic responses. So led to uh some agorophobic responses. So we'll talk about differential diagnoses we'll talk about differential diagnoses in a minute. Uh review of symptoms in a minute.

Defining PTED and related constructs

Uh review of symptoms however revealed anxiety, insomnia, however revealed anxiety, insomnia, depression, loss of appetite, depression, loss of appetite, irritability or verbal aggression to irritability or verbal aggression to others but no overt psychosis or mania others but no overt psychosis or mania and she also lacked some of the more and

she also lacked some of the more cardinal features of PTSD which we'll cardinal features of PTSD which we'll talk about in a bit. So think about this talk about in a bit. So think about this case. Um ask yourself what you might do case. Um ask yourself what you might do if you're encountering such um you know if you're encountering such um you know intense embitterment if you will or intense embitterment if you will or anger around illness and what it's done anger around illness and what it's done to somebody psycho behaviorally etc to somebody psycho behaviorally etc whether you would treat it differently whether you would treat it differently refer to a colleague etc. The second refer to a colleague etc. The second case from the inpatient setting is a case from the inpatient setting is a 61-year-old male with chronic uh uh COPD 61-year-old male with chronic uh uh COPD and asthma, congestive heart failure, and asthma, congestive heart failure, chronic pain. So number of issues also chronic pain. So number of issues also history of poly substance use admitted history of poly substance use admitted after a suicide attempt involving an after a suicide attempt involving an overdose with alprazil. After an initial overdose with alprazil. After an initial period of delirium, he presented with period of delirium, he presented with high irritability, dysphoria, cited his high irritability, dysphoria, cited his chronic pain and estrangement from chronic pain and estrangement from family as activating stressors and uh family as activating stressors and uh adding that he really had nothing else adding that he really had nothing else to live for. He lacked any formal to live for. He lacked any formal psychiatric history despite all of this psychiatric history despite all of this um and and you know except for anxiety um and and you know except for anxiety basically and demanded that he be on his basically and demanded that he be on his uh alprazilam you know 1 milligram four uh alprazilam you know 1 milligram four times a day right away even after having times a day right away even after having had this you know suicide attempt. He had this you know suicide attempt. He did not meet full criteria actually for did not meet full criteria actually for MDD despite everything. Um and uh he MDD despite everything. Um and uh he also denied core PTSD, panic, um also denied core PTSD, panic, um generalized anxiety symptoms when we generalized anxiety symptoms when we really look closely, manic psychotic really look closely, manic psychotic symptoms. So there probably more of a symptoms. So there probably more of a substance use disorder as described, but substance use disorder as described, but he spoke aidly about his experience as a he spoke aidly about his experience as a veteran of some wars and about veteran of some wars and about separation from family portraying each separation from family portraying each with a strong theme of victimization, with a strong theme of victimization, externalizing a lot. He felt rather externalizing a lot. He felt rather angry and embittered about these angry and embittered about these experiences as well as about his experiences as well as about his arthritis, chronic pain and as mentioned arthritis, chronic pain and as mentioned externalizing often. So these are two externalizing often. So these are two caricatures that might seem very caricatures that might seem very familiar to you. Uh you might see this familiar to you. Uh you might see this again ambulatory and uh inatient setting again ambulatory and uh inatient setting just to sort of cement the idea that just to sort of cement the idea that embitterment is at least a component of embitterment is at least a component of this maybe not the full explanation but this maybe not the full explanation but certainly a component. So what is PTE?

certainly a component. So what is PTE? PTED again not in the DSM and and I'm PTED again not in the DSM and and I'm not even certain that it needs to be.

not even certain that it needs to be. I'm just sharing the construct is uh is I'm just sharing the construct is uh is characterized by these criteria. I'm not characterized by these criteria. I'm not going to go over every single word, but going to go over every single word, but um you see that uh some negative life um you see that uh some negative life event, it could be medical, it could be event, it could be medical, it could be non-medical, has activated a cascade of non-medical, has activated a cascade of these um you know uh embitterment these um you know uh embitterment feelings, unjust, you know, uh feelings, unjust, you know, uh experiences, that residue, if you will.

experiences, that residue, if you will. Um no other mental health disorder, you Um no other mental health disorder, you know, would explain it otherwise prior know, would explain it otherwise prior to that. And you do need six months uh to that. And you do need six months uh duration of this kind of like with PTSD duration of this kind of like with PTSD and other DSM categories. Again, this is and other DSM categories. Again, this is what has been proposed, not necessarily what has been proposed, not necessarily advocating for it or anything of that advocating for it or anything of that sort. Um the scholars are right about sort. Um the scholars are right about this uh right that there are this uh right that there are embitterment subtypes if you will. This embitterment subtypes if you will. This might help us think phenotypically about might help us think phenotypically about what we're seeing. So PT is PTED what we're seeing. So PT is PTED reaction, you know, uh after one event, reaction, you know, uh after one

event, which is the previous definition.

which is the previous definition. complex embitterment stemming from complex embitterment stemming from multiple situations of perceived multiple situations of perceived injustice. This uh might rub a little injustice. This uh might rub a little bit, you know, up against demoralization bit, you know, up against demoralization as we were talking about with prolonged as we were talking about with prolonged hospitalization, non-reactive hospitalization, non-reactive embitterment in embitterment prone embitterment in embitterment prone personality, which is interesting. Uh we personality, which is interesting. Uh we don't have time today to unpack all of don't have time today to unpack all of these different nuances, but maybe there these different nuances, but maybe there is a personality subtype that is more is a personality subtype that is more prone to developing this. And then prone to developing this. And then secondary and vitamin in the context of secondary and vitamin in the context of some other mental disorder. So you can some other mental disorder. So you can see there's obviously a lot of dynamic see there's obviously a lot of dynamic interplay between between different interplay between between different factors that we consider this construct.

factors that we consider this construct. And then of course there's diagnostic And then of course there's diagnostic overlap as is often the case in our overlap as is often the case in our field. We see individuals with one two field. We see individuals with one two maybe three different diagnosis. Um here maybe three different diagnosis. Um here you have a ven diagram just reminding us you have a ven diagram just reminding us that we have adjustment disorder PTSD that we have adjustment disorder PTSD and then this uh other construct of and then this uh other construct of PTED. And I'm not going to review all of PTED. And I'm not going to review all of the elements, but you can see some of the elements, but you can see some of the differentiating factors, but some of the differentiating factors, but some of the overlap as well. Obviously, they the overlap as well.

Validation and case-based intervention

Obviously, they share a significant reaction to uh an share a significant reaction to uh an event. It's interesting that depression event. It's interesting that depression is in the middle there. I'm not is in the middle there. I'm not convinced that you'll always have convinced that you'll always have depression, but uh with these three, but depression, but uh with these three, but that's okay.

that's okay. So um because this is a new construct So um because this is a new construct because I'm really just sharing it with because I'm really just sharing it with the academy and seal psychiatrist to add the academy and seal psychiatrist to add to the lexicon we really don't know much to the lexicon we really don't know much about how to manage this if you will um about how to manage this if you will um obviously there are many you know obviously there are many you know empirically validated psychotherrapeutic empirically validated psychotherrapeutic strategies for the person who has strategies for the person who has embitterment generally anger issues etc embitterment generally anger issues etc but um when thinking about this in our but um when thinking about this in our CL practice especially if we don't have CL practice especially if we don't have other other resources is, you know, other other resources is, you know, sometimes the MD is going to have to uh sometimes the MD is going to have to uh dip into their psychotherrapeutic dip into their psychotherrapeutic toolbox. And I'm just reminding the toolbox. And I'm just reminding the audience with this image of um Glenn audience with this image of um Glenn Gabard's contribution during many of our Gabard's contribution during many of our psychiatric residency training psychiatric residency training experiences of the of the continuum of experiences of the of the continuum of of psychotherrapeutic interventions, of psychotherrapeutic interventions, right? On one end, expressive ones and right? On one end, expressive ones and on the other end, supportive ones. And on the other end, supportive ones. And if you can imagine somebody who's if you can imagine somebody who's seething and embittered, you're going to seething and embittered, you're going to probably want to have to hover over on probably want to have to hover over on the right side of this page uh with the right side of this page uh with supportive uh statements actually very supportive uh statements actually very uh much in line with the previous uh much in line with the previous presentation, the second case that you presentation, the second case that you presented. You're going to have to u presented. You're going to have to u engage in some of that um you know engage in some of that um you know validating all of that. So one position validating all of that. So one position that I'm going to just propose is that that I'm going to just propose is that we leverage empathic validation we leverage empathic validation regularly obviously with quote difficult regularly obviously with quote difficult patients embittered

or not in our patients embittered or not in our clinical setting. Um I'm sharing an uh a clinical setting. Um I'm sharing an uh a case that I wrote once with a trainee um case that I wrote once with a trainee um where we had an individual who was in where we had an individual who was in the hospital for very long a couple of the hospital for very long a couple of months after ARDS bout and um he was months after ARDS bout and um he was really sort of checked out not engaging really sort of checked out not engaging with too many folks ruled out major with too many folks ruled out major depressive disorder ruled out uh depressive disorder ruled out uh inphylopathy inphylopathy inphylopathy u but we knew that behaviorally u but we knew that behaviorally something was going on and we basically something was going on and we basically identified during this case that identified during this case that empathically valid validating. In other empathically valid validating. In other words, acknowledging, recognizing what words, acknowledging, recognizing what the individual was going through was a the individual was going through was a key to to getting through that moment.

key to to getting through that moment. And uh for those interested, I'm not And uh for those interested, I'm not going to read this this script, but in going to read this this script, but in the article, we purposely included the the article, we purposely included the actual language that we used with the actual language that we used with the patient because it unlocks maybe some patient because it unlocks maybe some tips as to what to do with future tips as to what to do with future patients. I'm going to skip because we patients. I'm going to skip because we only have a minute, but essentially we only have a minute, but essentially we started the script by coming in as wrote started the script by coming in as wrote physicians and doing what we always do, physicians and doing what we always do, the ano x times three dance and all of the ano x times three dance and all of that. And we realized midway that the uh that. And we realized midway that the uh patient was very frustrated by us doing patient was very frustrated by us doing the same thing that everyone else does.

the same thing that everyone else does. And we caught ourselves and had to call And we caught ourselves and had to call that out. And he was very embittered by that out. And he was very embittered by this process and feeling dehumanized. Um this process and feeling dehumanized. Um so again in the interest of time I'm so again in the interest of time I'm only going to skip to a little bit of only going to skip to a little bit of this but uh right in the second doctor this but uh right in the second doctor there where you see um he's actually the there where you see um he's actually the patient is saying Mr. else saying it's patient is saying Mr. else saying it's not okay to do these tests, right? The not okay to do these tests, right? The same, you know, tests, you know, * 3 same, you know, tests, you know, * 3 again. And we caught ourselves and said, again. And we caught ourselves and said, you're absolutely right. It's not okay.

you're absolutely right. It's not okay. I just realized we're doing what we said I just realized we're doing what we said is a big problem here, the repetitive is a big problem here, the repetitive test. He says, "Yeah, we can't do that test. He says, "Yeah, we can't do that all the time." Whether it's the nurses all the time." Whether it's the nurses or the doctors, they just keep doing the or the doctors, they just keep doing the same thing, checking you here, examining same thing, checking you here, examining you there, and and then he adds to that you there, and and then he adds to that and pulling the sheets, the gowns, and pulling the sheets, the gowns, grabbing my arm, and we assist, right?

grabbing my arm, and we assist, right? Oh, the blood pressure thing. Yes. So Oh, the blood pressure thing. Yes. So you see how we're sort of in similar you see how we're sort of in similar territory territory territory validating the experience and said right validating the experience and said right all of that enough is enough and then we all of that enough is enough and then we said we did the same thing you've been said we did the same thing you've been sick and tired of and we we know from sick and tired of and we we know from our demoralization definitions we love our demoralization definitions we love the terminology of being sick and tired the terminology of being sick and tired of being sick and tired. That has to be of being sick and tired. That has to be extremely upsetting. That's the extremely upsetting. That's the validation that it keeps happening. We validation that it keeps happening. We don't need to do that exam and maybe we don't need to do that exam and maybe we simply talk and that'll be best. And simply talk and that'll be best. And from here, since we're out of time, I from here, since we're out of time, I can't tell you more. But what did can't tell you more. But what did happen, it was a turning point where he happen, it was a turning point where he really started to embrace physical really started to embrace physical therapy and some other strategies to get therapy and some other strategies to get out of the hospital. So, it's very akin out of the hospital.

Wrap-up and future directions

So, it's very akin actually to the previous presentation in actually to the previous presentation in terms of how we use our language, terms of how we use our language, perhaps our virtue ethics and our perhaps our virtue ethics and our behaviors, but also psychother behaviors, but also psychother psychotherrapeutic principles like psychotherrapeutic principles like empathic validation to get through that empathic validation to get through that embitterment and not necessarily embitterment and not necessarily characterize it as difficult, if you characterize it as difficult, if you will. So, future directions, I'm will. So, future directions, I'm wrapping up. I I do think this construct wrapping up. I I do think this construct demands or deserves more research demands or deserves more research particularly in medical settings and we particularly in medical settings and we should despite whether you use the should despite whether you use the construct or not we should of course construct or not we should of course tailor our clinical interventions around tailor our clinical interventions around the presence of embitterment identify it the presence of embitterment identify it call it out uh the the sense of of you call it out uh the the sense of of you know injustice etc and consider that know injustice etc and consider that impact on medical populations and maybe impact on medical populations and maybe reconceptualize our patients as reconceptualize our patients as embittered and not so much difficult if embittered and not so much difficult if you will. Obviously training around this you will. Obviously training around this would be the the next step after that.

would be the the next step after that. Thank you for your attention and there's Thank you for your attention and there's references here for those who are references here for those who are interested.