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Section I: Introduction/General Concepts

Meanwhile, demanding, “entitled,” or rudely behaving patients and families are troubling—even infuriating—to many physicians, nurses, and ICU staff. Occasionally, these difficult staff–patient exchanges arise from problems with the care providers themselves; factors such as depression, anxiety, overwork, sleep deprivation, longstanding interpersonal rigidity, and the cumulative effects of stress (1,2) may cause some physicians and nurses to fail to adequately address the emotional needs of their patients and patients’ families (3,4). At other times, patients and families with markedly impaired abilities to negotiate interpersonal relationships become overwhelmed and subsequently act in ways that are extremely problematic. The judgment of these families and patients can become clouded by longing, shame, rage, and despair, making reasoning with them almost impossible. In this chapter, we endeavor to relieve the critical care practitioner of some of the fury that problematic patient and difficult family member encounters engender, offer some reason where none seems to exist, and provide suggestions for less alarming, routine ICU interactions. Herein, we pose—and offer practical answers to—the following questions:

- What is the psychological impact of critical illness and ICU treatment on patients and families?
- Why are some patients and families so taxing to deal with and others so easily treated, soothed, and able to be active team members?
- How should one approach problematic interactions with patients?
- What are some tips for enhancing communication between staff and family members?
- What are some ways to handle family requests for children to visit the ICU?

INITIAL STEPS

The psychological impact of critical illness and ICU treatment on patients and their families can be very powerful. Although problematic patient–doctor interactions are often due to emotional or relationship factors, there are many steps (Table 3.1) that can be taken before focusing on these factors. First, when one encounters a problematic patient, the initial questions should be: “Do I feel safe?” and “Are the other patients and staff feeling safe?” Physicians are taught to override their sense of danger. As medical students and interns, they begin placing catheters and doing lumbar punctures, charging through their fears. This sometimes translates to physicians overriding their inner sense of “danger” when managing potentially violent patients, a situation possibly leading to injury. It is thus important for physicians and nurses to “tune in” (5) to their inner sense of “danger” when managing potentially violent patients, a situation possibly leading to injury. It is thus important for physicians and nurses to “tune in” (5) to their sense of alarm and, when necessary, to call on security personnel, administer calming medications, or apply temporary physical restraint. The principle also applies to angry or threatening personnel, administer calming medications, or apply temporary physical restraint. The principle also applies to angry or threatening staff members, if any. ICU patients acting in a bizarre or agitated manner often do so as part of a delirium. This may entail suffering persecutory delusions that staff members are torturing them or hallucinations that are arresting frightening. Since delirium can be lethal (6), it is very important to first discover and treat the underlying causes of delirium and to administer treatment for agitation, which may include a sedative or slowing of calm pharmacotherapy, including neuroleptics. A full discussion of delirium is provided in Chapter 150 of this textbook.

In addition, a number of patients come to the ICU with established psychiatric diagnoses, including major depression, anxiety disorders, substance abuse, and schizophrenia. Occasionally, discontinuation of a patient’s outpatient psychopharmacologic medication is performed purposefully (7). In other instances, admitting physicians fail to review the outpatient medication lists, and unintended disruptions (8) in the proper treatment of a patient’s psychiatric illness ensue. This can lead to some patients suffering panic attacks, and cause others psychotropic exacerbation with paranoia and hallucinations. Some patients experience discontinuation phenomena, such as the fatigue and myalgias associated with abrupt cessation of serotonergic reuptake inhibitors (SRIs), or outright withdrawal syndromes specifically related to sudden discontinuation of alcohol, stimulants, narcotics, or sedative medications. Hence, on admission, it is important to learn about a patient’s psychiatric and substance abuse history, and to find out what medications, if any, have been useful in the past in treating their illness or

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**TABLE 3.1**

**A HIERARCHY OF QUESTIONS TO ADDRESS WHEN CONFRONTED WITH DIFFICULT PATIENT–DOCTOR INTERACTIONS IN THE INTENSIVE CARE UNIT (ICU)**

<table>
<thead>
<tr>
<th>SAFETY</th>
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<tr>
<td>Are staff and other patients safe? If not, how can we secure the safety of the unit?</td>
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<tr>
<th>DELIRIUM</th>
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<tr>
<td>Is the patient suffering delirium? If so, is the etiology of this delirium being effectively addressed?</td>
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<tr>
<th>PSYCHIATRIC ILLNESS</th>
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<tr>
<td>Does the patient have an anxiety, mood, or psychotic disorder or another psychiatric illness? If so, is adequate treatment for these conditions being given?</td>
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<tr>
<th>INTOXICATION AND WITHDRAWAL</th>
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<tbody>
<tr>
<td>Is the patient intoxicated with alcohol and/or other substances? Is the patient withdrawing from alcohol or other substances? Are we addressing the untoward effects of withdrawal?</td>
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<tr>
<th>PSYCHOSOCIAL STRESSORS</th>
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<tr>
<td>Can we reduce pain, sleeplessness, isolation, and other stressors related to being in the ICU?</td>
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<tr>
<th>PERSONALITY PROBLEMS</th>
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<tr>
<td>What is the patient’s predominant mode of coping? How can we best manage this patient’s uniquely taxing mechanisms of defense and have a different type of relationship with the patient than the one we are having now?</td>
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</tbody>
</table>

potential withdrawal. At any point in this evaluation process, psychiatric consultation may be helpful.

Typically, before examining psychological factors leading to problematic ICU staff–patient relationships, it is important to maximize patient comfort. Remember, staff in the ICU grow very accustomed to their workspace. They may enjoy laughs with colleagues, coffee and doughnuts in the break room, or other comforts, while most patients are miserable with pain, endotracheal tube discomfort, ICU noise, sleeplessness, and isolation (9,10). Working hard to minimize these factors by providing adequate analgesia, effective sleep agents, uninterrupted time with family and loved ones, and efficient use of tubes and catheters may reduce some of the patient discomfort that drives disruptive behavior.

EXISTENTIAL CONCERNS OF PATIENTS AND FAMILIES IN THE INTENSIVE CARE UNIT

Being an ICU patient, or having a loved one who is critically ill, is intensely stressful (11,12). Studies indicate that 3 months after patients are treated in the ICU, approximately one third of caregivers and family members are at risk for depression (13) and posttraumatic stress disorder (14). Patients’ most prominent concern early in their ICU stays involves how they feel physically. Pain, hunger, restless exhaustion, the irritation of tubes and catheters, and isolation are the predominate focus of the acutely ill individual; it is usually not until the convalescent or subacute period in the patient’s hospital course that larger, existential crises and psychological problems come to the forefront (15).

Critical illness raises many existential concerns for patients and loved ones. Lacking in the minds of patients and family members of ICU patients is the prospect of death, with critically ill individuals often reflecting on their lives. Confronting death may fill them with guilt, regret, and wishes that they could have accomplished more. In others, this may be a time of contentment and reflecting on lives well lived. Amazingly, this can occur even in a delirious patient. For example, one 80-year-old gentleman who had undergone emergency cardiac bypass surgery happily shared that, amid his postoperative delirious days, he “went on a train trip in my head, with stops along the way involving each stage of my life. My marriage, the birth of my children, the child we lost, the different businesses I had run, everything was in there.” Family members also reflect on their former lives, often viewing ICU stays as an opportunity to reevaluate their priorities. Without their awareness, and to the amazing extent, most families and patients are able to muster inner strength, gain security from each other or draw on outside resources, and cope well in times of adversity. While such families and patients may continue to suffer stress and depressive symptoms, their mature psychological coping mechanisms (Table 3.2) allow them to work smoothly with ICU staff.

On the other hand, some families and patients are extremely difficult to manage in the ICU. Such individuals typically fall into two categories: (a) those with personality disorders, whose personal and professional lives were replete with problems before they entered the ICU; and (b) those who have simply regressed, utilizing primitive coping mechanisms that, outside the ICU, would be less apparent.

Personality disorders refer to severe, pervasive exaggerations of normal personality traits—styles of dealing with the world (15). As the focus of intensive care medicine is on the here and now, and major psychosocial investigations of a patient or family member’s life outside the unit are inappropriate, distinguishing between the two categories is unnecessary in this chapter. Also, for the sake of convenience, we refer only to the “personality-disordered patient”; however, please note that the descriptions provided may also characterize family members. Note also that these descriptions also encompass the more rare, “easy-going” family member or patient who is simply pushed between, on the one hand, being excited that the ICU patient or friend after hospitalization. Ambivalence and tension between, on the one hand, being excited that the ICU patient has survived and, on the other hand, concern about his or her quality of life and how to handle extreme medical problems in the long term cause many patients and family members psychological suffering.

There are pressing concerns about the present as well. Most patients are treated in the ICU because their bodies fail to handle the most fundamental tasks of life. Whether involving breathing on their own, feeding themselves, or handling secretions, urination, and bowel movements, ICU patients are often dependent on others. This leads many patients to feel loathsome—somewhat. Still others may long for exceeding amounts of attention, reacting to the loss of autonomy with complete resignation. Loved ones, particularly those who are caretakers of chronically ill individuals, also feel the sting of this loss of autonomy. For example, one woman who, for several years, had taken care of her husband suffering end-stage Parkinson disease tenably commented: “It’s not just that my husband’s sick; it’s that I have to trust you doctors and nurses to take care of him. That’s my job.”

COPING IN THE INTENSIVE CARE UNIT

It is difficult to bear the intense feelings of pain, love, loss, regret, and hope that being treated in the ICU, or having a loved one treated for critical illness, engenders. Families and patients vary in their ability to tolerate these emotions. To an amazing extent, most families and patients are able to muster inner strength, gain security from each other or draw on outside resources, and cope well in times of adversity. While such families and patients vary in their ability to tolerate stress and depressive symptoms, their mature psychological coping mechanisms (Table 3.2) allow them to work smoothly with ICU staff. Patients with personality disorders have difficulty tolerating affect, or emotion. They also demonstrate impaired reasoning, thus compromising their ability to subdue intense feelings. Further complicating matters, they often have difficulty distinguishing what others are feeling and their own motives and tendencies (15). Without their awareness, and to the
### TABLE 3.2

<table>
<thead>
<tr>
<th>Defense</th>
<th>Description</th>
<th>ICU-relevant examples</th>
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<tbody>
<tr>
<td><strong>NARCISSISTIC DEFENSES</strong></td>
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<tr>
<td>Denial</td>
<td>Failing to be aware of some aspect of reality in order to avoid the painful consequences of facts, despite otherwise intact reality testing.</td>
<td>A patient denies that she has cancer, refusing to talk about hospital aftercare, convinced that: “It’s just a cough. I’m fine.”</td>
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<tr>
<td>Distortion</td>
<td>Molding reality to fit one’s need to feel superior, attractive, or powerful.</td>
<td>A patient protects against feeling ill and romantically unappealing by convincing himself that: “My doctor always smiles at me seductively. I bet on the outside we’d go out on a date.”</td>
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<tr>
<td>Projection</td>
<td>Placing one’s unacceptable inner urges and affects outside the self, often projecting them (like a movie projector) onto the screen of another individual.</td>
<td>A patient with many regrets says: “I bet my wife and kids wish they had treated me more nicely.”</td>
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<tr>
<td><strong>IMMATURE DEFENSES</strong></td>
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<tr>
<td>Acting out</td>
<td>Giving into an impulse to relieve inner tension, gratifying this wish without regard for the consequences.</td>
<td>An anxious son lights up a cigarette at his father’s bedside, sending the ICU into a panic.</td>
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<tr>
<td>Passive-aggressive action</td>
<td>The use of procrastination, failing to do something, and other devices that cause disruption to either the individual or others but appear benign.</td>
<td>An intern neglects to dictate a transfer summary for a patient whom the day before she admitted she found “totally obnoxious.”</td>
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<tr>
<td>Regression</td>
<td>Reverting to an earlier developmental stage using the strategies from that developmental era to tackle a stressful event or set of emotions.</td>
<td>A 24-year-old college senior admitted after a motor vehicle collision feels that her friends, family, and she are quite vulnerable. She thus cradles a teddy bear and uses “baby talk,” elicting paternal/maternal responses from the ICU staff and bringing to mind the security she felt as a child.</td>
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<tr>
<td>Somatization</td>
<td>Converting psychological stress into physical symptoms.</td>
<td>After hip replacement, a patient who “can’t stand” her physical therapist refuses to get out of bed for this treatere because her leg legitimately throbs with pain whenever the therapist enters the room.</td>
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<tr>
<td><strong>NEUROTIC DEFENSES</strong></td>
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<tr>
<td>Controlling</td>
<td>Scheduling or managing aspects of a painful event or problem in order to alleviate anxiety.</td>
<td>A patient’s daughter routinely demands a review of his medication, medication doses, lab test results, and imaging studies.</td>
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<tr>
<td>Displacement</td>
<td>Transferring overwhelming emotions and thoughts related to one entity to another, which shares similar features.</td>
<td>A woman whose husband has emphysema is disappointed with him for not quitting cigarettes; in displacement, she yells at her adult son who is eating a cheeseburger and fries in the hospital cafeteria, saying: “You need to lose weight and eat more healthy foods!”</td>
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<tr>
<td>Intellectualization</td>
<td>Much like controlling, involves excessive focus on the intellectual aspects of illness or hospitalization.</td>
<td>A physician is very anxious about her husband’s spine surgery and convalescence and asks questions ad nauseam about the surgeon’s approach and the materials used rather than sitting at her husband’s bedside.</td>
</tr>
<tr>
<td><strong>MATURE DEFENSES</strong></td>
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<tr>
<td>Anticipation</td>
<td>Realistically looking at the future and making management plans for upcoming challenges.</td>
<td>A father, whose wife is dying in the ICU, asks the patient’s social worker for a referral to a grief support network for her daughter and himself, saying: “Right now I can’t even think straight, but I know this is going to be hard and we’ll need help.”</td>
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<tr>
<td>Humor</td>
<td>Utilizing comedy to help oneself and others acknowledge and tolerate painful aspects of reality.</td>
<td>While rolling to the operating room for leg amputation, an elderly woman drily comments to the medical student: “You think my pedicures will be half-price?”</td>
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<tr>
<td>Sublimation</td>
<td>Accepting that one’s impulse is socially unacceptable, adapting it into one that is useful and gratifying.</td>
<td>A college student visiting a friend hates how emotionally sterile the ICU environment is and would like to scream at the doctors and nurses. Instead, she becomes determined to go to medical school and become a warm, empathic physician.</td>
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<tr>
<td>Suppression</td>
<td>Consciously delaying focusing on a painful topic or aspect of reality, saving it for later.</td>
<td>A family who desperately wanted their grandmother to be part of a wedding service is concerned that she will not survive a subdural bleed. Wisely, the bride’s mother counsels: “This is upsetting, but let’s just cross that bridge when we come to it. For now, let’s work on taking good care of grandma.”</td>
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surprise of their caretakers, such individuals consistently em-
ploy defense mechanisms, which cause disruptions that take on
a life of their own. To make matters worse, let us examine a
simple hypothetical, toxic hospital interaction:
A nurse's aide asked a mendicent middle-aged litigant recovering
from back surgery what he wanted for the forthcoming day's meals.
The man handed this caretaker his menu and barked: "I want some
descant food, not the crap you serve here!" Caught off-guard, the
nurse's aide picked up the menu, but distracted by the man's rude-
ness, left it by the sink after she left the room. The next day, when
the nurse arrived on the man's tray, he detected the attrac-
tive and typically savvy staff member as "ugly," "incompetent,"
and "worthless." He complained bitterly to everyone who entered
his room about this woman and the "dietary travesty" for the rest
of the day.

Some may argue that clinicians simply need to work with a
patient's overt behavior: "What you see is what you get. Deal
with it!" Accordingly, these people argue that our job in the ICU
is not to delve into the motivations driving a patient's actions or
feelings. Such folks may simply dismiss the attorney's behavior
as rude and note that he had a finicky palate. Alternatively, we
contend that investigating the emotions and inner conflicts un-
derlying the man's rudeness offers a deeper, more sympathetic
version of what occurred. We can first speculate that this man,
a powerful lawyer outside the hospital accustomed to getting
his own lunch and going to the bathroom without the aid of a
bedpan, felt extremely "incompetent." Perhaps used to know-
ing every aspect of his client's cases and his staff's work, he
also loathed the idea of the medical and surgical staff knowing
more about his magnetic resonance imaging (MRI) scan, labs,
and even his lunch time than he did. Finally, he may also have
been hurt by the nurse's aide's abrupt and crude treatment and
sitting in bed wearing a hospital Johnny, felt that he him-
self looked very ugly. Through his brief comment, the man was
able to redirect his intolerable feelings. He turned his sadness
into hostility and projected his feelings of incompetence onto
the nurse's aide. She, in turn, felt flustered and perhaps an-
gry, "accidentally" (passively aggressively) left his menu by the
sink. He was also able to defend against his concern of not
knowing what is supposed to happen in the hospital, by
pointing out that he knows he was getting the wrong meals,
and was able to engage his doctors and nurses in a discussion
about his food as opposed to his medical treatment. Thus, the
man's defenses took on a life of their own with conflict over a
breakfast tray, thereby distracting from his chief psychological
problems. In this case, the man's behavior falls in the "narcissis-
tic" category, which represents one of the four main, difficult
troubles. In this case, the man's behavior falls in the "narcissis-
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tic" category, which represents one of the four main, difficult

Chapter 3: Understanding Reactions of Patients and Families

The Narcissistic Patient

Patients in the ICU lose autonomy. In almost every way, they
are at the mercy of ICU staff and visitors, leading many pa-
tients to feel infantilized. For most patients, then, regaining
a sense of control over their lives is important. Meanwhile,
for the narcissistic patient, this need takes on an overwhelm-
ing, life-or-death urgency. Narcissistic patients approach the
world in a grandiose fashion with an exaggerated sense of self-
importance. They typically believe they are special and unique,
requiring excessive admiration. They have significant problems
with empathy and feel a strong sense of entitlement for care,
concern, or special treatment (17). If they fail to receive these
"entitlements," they attack, sometimes ruthlessly. It should be
noted that these traits often are responses to underlying feelings
of insecurity, low self-esteem, ineffectiveness, and profound
feelings of deprivation—typically stemming from neglectful in-
teractions in their childhood. Despite their overt demonstra-
tions of strength and power, in reality they feel weak and fragile;
it is crucial to recognize that they are not in touch with these
underlying feelings, and that if confronted, they will freely
deny and reject that they have them.

Occasionally, as the example above demonstrates, the nar-
cissist's need for control and special care may take the form
of scathing critique concerning the health care staff. These pa-
tients often deride nurses ("That's the wrong bandage!"), be-
little housestaff ("You must be new at this, Doogie"), and drop
names ("Dr. Thompson, the world famous nephrologist, is a
buddy of mine from college; he never allows patients to be
accepted like this") to demonstrate their "connections." Staff re-
actions to such patients include rage and revulsion when they
are the subject of derision, or, more commonly in more junior
house officers, nurses, or staff, feelings of inadequacy or infe-
riority when a patient presents as an entitled, very important
patient (VIP).

Insofar as possible, it is best to collaborate with—rather
than confront—this type of patient. To avoid caustic exchanges
ending in both the patient and physician feeling hurt or en-
raged, one must choose to have a different relationship with
the patient, which can be accomplished by avoiding authori-
tarian condescension and appealing to the patient's narcissism.
Remember, when narcissistic patients examine their surround-
ings in the ICU, all they see are their inadequacy, inability,
and incapacity. The nasogastric tube attached to the churning
pump reminds them that they cannot nourish themselves; the
ventilator brings to mind that they cannot breathe on their
own; the bedpan is a glaring reminder that they cannot even
relieve themselves independently. When a physician or nurse
uses a tone of voice that conveys respect, and chooses words
that remind patients that, despite their infirmities, they are still
valuable people, he or she is able to meet patients' needs, of-
fering them the respect they so desperately crave. This may
entail calling patients "we," "ma'am," "Mr.," "Mrs.," "Doc.,"
or "Professor" as appropriate. It is also useful to ask narcissis-
tic patients about their lives before they came down with the
debilitating illness. This promotes the notion that you think of
these patients as vital, able-bodied individuals who happen to
be suffering severe infirmity, as opposed to thinking of them as
fragile nonentities—a patient's worst fear.
Narcissistic patients appreciate gaining as much control as possible. Hence, even controlling their light switch and TV,
using patient-controlled analgesia, or being able to choose to
"go first" or "go last" when the phlebotomist performs rounds
helps patients feel like more of a collaborator in their care.
Finally, avoiding power struggles with narcissistic patients is of
the utmost importance. For example, a psychologically minded
ICU nurse who was typically well liked by staff and patients
was being bossed around by a VIP, who eventually asked for
a different nurse. Rather than be offended, the nurse simply
exchanged patients with a colleague. She offered: "Hey, when
I was young I would have been offended and told him 'I am
your nurse and you are stuck with me.' But he's not in the ICU
every aspect of ICU life. Often these entreaties are the same as

to conjure a mental image of his mother when she’s out of sight
dilder, the dependent patient has poor object permanence, unable
psychiatric terms, we would state that, similar to the early tod-
bers, often engendering feelings of disdain and aversion. Clin-
needs of the dependent patient involves frequent visits and
icu staff to distraction.

TABLE 3.3

| COMMON PROBLEMATIC PERSONALITY STYLES ENCOUNTERED IN THE INTENSIVE CARE UNIT (ICU) |
|----------------------------------|----------------------------------|----------------------------------|
| Personality type | Core deficit | Characteristic behavior | Suggested response |

**Dependent**
- Hypersensitive to abandonment, inadequacy, and
- Unending need for nurturance and support
- Demands special care
- Childlike, cries easily and complains of abandonment and insufficient care
- Schedule exam and rounding times
- Anticipate nursing staff changes, physician care shifts, and transfer to floor.
- Validate patient’s plight and offer to help within reason.
- Enlist family members for support
- Support nurses and colleagues who may need to spend extra time with these patients

**Narcissistic**
- Hypersensitive to loss of control and stature; defended against looking weak
- Denies severity of illness
- Shows bravado
- Critical of ICU staff and care
- Acknowledge patient’s stature.
- Enlist patient as active partner in care and decision making.
- Schedule patient and family meetings.
- Have a set amount of information to share with patient and family.
- Provide factual, as opposed to nuanced, explanations of data.
- Avoid emotional commentary or inquiry and avoid authoritarian approach.

**Obsessive**
- Hypersensitive to loss of control; defended against the unknown; craving mastery
- Excessive focus on medical facts and minutiae
- Rigid, with restricted affect; not apt to “show emotional cards”
- Engaging and charming to some staff, derisive and caustic to others
- May have multiple allergies and phobias
- May “fire” some staff, take exceptions to rules, and seek intimate connections with others
- Acknowledge patient’s positive attributes
- Validate patient’s plight and offer to help within reason.
- Discuss patient with colleagues and set limits, as necessary, as a team.

**Dramatic**
- Difficulty feeling cared for or thought of except within emotionally extreme exchanges; minor insults felt deeply
- Engaging and charming to some staff, derisive and caustic to others
- May have multiple allergies and phobias
- May “fire” some staff, take exceptions to rules, and seek intimate connections with others
- Acknowledge patient’s positive attributes
- Validate patient’s plight and offer to help within reason.
- Discuss patient with colleagues and set limits, as necessary, as a team.


The Dependent Patient

Dependent patients are hypersensitive to being alone and suffer intense anxiety. These individuals feel empty and isolated, often because they came from families that never provided adequate caretaking. They cling tenaciously to clinicians or family members, often engendering feelings of disdain and aversion. Clinicians are typically idealized and considered endowed with superhuman powers. Such patients have an inability to hold onto the comforting feelings they receive from ICU staff, friends, or relatives when those people are not actively helping them. In psychiatric terms, we would state that, similar to the early toddler, the dependent patient has poor object permanence, unable to conjure a mental image of his mother when she’s out of sight (18). Thus, these patients demand urgent assistance with nearly every aspect of ICU life. Often these entreaties are the same as one would expect any hospitalized person would want. Better food, more analgesia, softer pillows, more frequent visits and doctor reports, enhanced light, nicer views, gentler exams, and fewer tubes and catheters. However, for the dependent patient, these concerns take on an overwhelming urgency, often driving ICU staff to distraction.

Addressing—as opposed to avoiding—the relationship needs of the dependent patient involves frequent visits and keeping the patient informed. Nurses and doctors should let such patients know when they plan to come back into the room, when rounds might take place in the morning, when transfer to another ward will happen, and when tests will take place. For many dependent patients, this basic information will not be enough to soothe their demands for instant anxiety relief. In these situations, the nurse-patient or physician-patient relationship can be transformed by (a) validating that the patient’s concerns are real, (b) communicating to the patient that his or her request is understood, and (c) explaining to the patient that the staff will do everything in their power to help, but that it may not be possible to provide everything the patient demands.
The Obsessive Patient

Obsessive individuals are emotionally constricted and rigid. They tend to focus on minute details and lose the big picture. They are compelled to make the “right” or “perfect” decision based on “facts” and never feel that they—or their caregivers—have all the information to provide optimal treatment. Consequently, they are intensely frustrating to providers, who feel assaulted by endless questions and devalued, as the provider never has the patient’s confidence in treatment decisions (15). Caring for the patient or family member who pays obsessive attention to detail and routine can be very taxing. By clinging to the “rules of medicine” as a 7- to 10-year-old child might adhere to the rules of a board game, the obsessive patient can irritate physicians and nurses. In contrast to narcissistic patients, who regain control over their surroundings via denial, distortion, and bullying behavior, obsessive individuals defend against feelings of helplessness by focusing on medical minutiae. The obsessive logic goes: “a place for each thing and each thing in its place” (19). Of course, everything in the ICU is out of place; patients do not know what their radiographs show right away; their labs are a mystery to them for several hours, even days; and the meaning of the blips and bleeps of monitors buzzing around them is not understood. So, with very rudimentary medical knowledge, the obsessive patient or family member works hard to gain mastery over these details. Losing the forest for the trees, the obsessive patient asks incessant questions. For example, one woman with Guillain-Barré syndrome demanded to know why she was not being transfused when she saw an “L” marked next to her “HCT” of 32.3%. When her nurse sat down next to her bed, summarized her lab report, and explained the team’s management rationale, the patient felt knowledgeable and was soothed. Again, dealing with this type of difficult patient interaction takes extra time and a firm decision on the practitioner’s part to have a different relationship with the patient. Obsessive patients cannot stand the paternalistic, authoritarian approach, and the practitioner who is not flexible will get into fruitless standoffs with these patients. Statements such as “you just rest and let us take care of you” are intensely irritating to the obsessive patient. Instead, offering the obsessive individual a set amount of information, with a satisfying but not overwhelming amount of detail, can be key. This may mean showing the obsessive patient or family member a chest radiograph or reviewing their “lytes” at bedside. Second, the obsessive patient, like all patients, appreciates routine. Announcing and, insofar as possible, keeping to a schedule in which nurses and physicians will visit is important. Finally, scientific, deductive reasoning (“if your labs show X, then we’ll respond by doing Y”) curbs the obsessive patient’s anxiety.

The Dramatic Patient

Linked to many instances in early childhood trauma and because they have intense difficulty identifying their own affective state, in distinguishing how they think and feel from how others think and feel (20), dramatic patients fail to recognize subtlety. They thus engage in highly volatile relationships. In the hospital, these patients—many of whom suffer borderline personality disorder in the official psychiatric nomenclature (17)—engage their physicians and nurses in relationships that are intensely intimate or staggeringly conflictual. The dramatic patient often seduces some staff members and alienates others. This leaves ICU personnel at odds, with some having had a very positive experience with the patient, using phrases like “lovely,” “charming,” and “delightful” to describe the patient, and others considering the patient obstreperous or toxic. When clinicians who have such divergent experiences with a dramatic patient convene, there is often a conflict over how to manage the patient’s demands. This experience is dubbed “splitting” and can create tremendous tension. The deleterious effects of splitting, which include mistreating the patient and high staff tension, are minimized when physicians and nurses acknowledge that they have had much different emotional experiences with a patient. Once this is done, limits can be set in a manner that both soothes the patient and settles the staff (Table 3.4).

Dramatic patients are also notorious for their hypersensitivity to physical pain and perceived slight and threat of abandonment by physicians and nurses. Similar to the dependent

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Table 3.4

PRINCIPLES OF EFFECTIVE LIMIT SETTING IN THE INTENSIVE CARE UNIT (ICU)

- Validate: Acknowledge the patient’s real struggles.
- Explain: Provide limits in a clear and concise manner and avoid overly euphemistic statements such as “Retrain from unsafe behavior.” Instead, say: “Please stop throwing things!”
- Be flexible: Before speaking with the patient, discuss as a team what the patient may ask for and what the ICU team can be flexible in offering. For example, can a patient begging for a cigarette be administered nicotine gum or a transdermal patch?
- Determine consequences: Know in advance how to handle transgression of limits; these do not necessarily need to be shared with the patient or his or her family, but can give the ICU team a sense of security.
- Avoid arguments: Long, drawn-out battles of wit or reason are rarely useful. Leaving the patient’s bedside in order to cool down, think of a new strategy, or consult a colleague is better than acting impulsively.

patient, validating the very dramatic patient’s feelings is key. Although the clinical staff may believe that dramatic patients are “exaggerating” or “faking” their symptoms, even if these assessments may be accurate, it is futile to believe that these concerns can be managed by approaches that entail feelings such as “I hope that they will just go away or stop if I ignore them.” One must have an explicit plan to improve the relationship with a patient. As one of our (CU) senior residents at Walter-Reed Army Medical Center once intoned, “If hope is not a course of action!” It can be immensely soothing to dramatic patients if you convey your understanding of their struggles and let them know that you are aware of many of the problems they are facing. Furthermore, asking, “Are there some problems that I’ve missed that we need to make certain we are helping with?”, can lead to further improvement in your relationship.

COMMUNICATING WITH FAMILIES IN THE INTENSIVE CARE UNIT

The ear says more Than any tongue.

W.S. Graham, “The Hill of Intrusion”

Family members and friends are not mere visitors to the ICU (21). They are often charged, sometimes reluctantly (22), with understanding a patient’s diagnosis, prognosis, and treatment options, in addition to making informed decisions when their loved one is unable to express his or her own medical care preferences. Family members also play an integral role in encouraging their critically ill spouses, siblings, aunts, and uncles. In addition, they may help nurses provide care, and often spend much time on the phone or e-mailing, communicating progress and problems to relatives and friends of the patient who cannot visit the ICU. A study by Pochard et al. found that the prevalence of depression in family members of intensive care unit patients was 69%, while 35% suffered marked anxiety (12). These symptoms may make it very hard for family members and loved ones to function in their roles as caretakers, nurturers, communicators, and decision makers while on the unit; moreover, it impacts their abilities as mothers, fathers, and employees outside the unit. Quality communication between ICU staff and family members of ICU patients is central to:

- Reducing family stress and dissatisfaction (23).
- Minimizing conflict surrounding end-of-life decisions (24).
- Decreasing futile interventions (25).
- Reducing friction between ICU staff and families (26).

Again, while some families may utilize maladaptive coping strategies or appear very similar to the personality profiles listed in Table 3.3, ICU staff committed to communicating with families stand the best chance of promoting patient and family security and alleviating suffering.

While each family and critical care situation is unique, following some general guidelines (Table 3.5) for interacting with families can be helpful. These include being clear and concise when explaining the medical information, asking to make certain the data are understood; scheduling appointments for family meetings; listening more and talking less; tuning in to those things that make the patient and family special (27); and providing early diagnostic and prognostic information, even if this involves admitting uncertainty (28). Keep in mind that most families rate the clinician’s ability to communicate above their clinical prowess (29).

Despite early, open dialogue between ICU clinicians and patients’ families, problems nevertheless will arise. Owing to stress, depression, and anxiety, some families may not want to participate in the decision-making process regarding their loved one’s care (22). Referral to unit support staff, including social workers who are able to assess the needs of family members, can be very helpful. At times, the family members’ judgment may be clouded by anger toward the patient. For example, the relatives of a patient who is being treated in the ICU following a suicide attempt may be upset at the patient for “wanting to leave them behind,” and hence may make decisions out of anger, frustration, and disappointment (30). If one senses that this is the case, bringing these feelings out into the open—what psychotherapists term “making the implicit explicit”—can help families consider treatment decisions more thoughtfully. Breakdowns in understanding and communication between clinicians and families occur when, wrought with guilt or a profound sense of duty, family members demand that staff “do everything possible” for the patient, even when aggressive care is futile. One scenario in which this occurs involves the distant son or daughter who has played a minimal role in his or her parent’s life and feels overwhelming guilt. Alternatively, family members may feel they “need” a relative so badly that losing him or her would be psychologically devastating. This may impair their reasoning to the point that they overinterpret subtle cues as signs that their loved ones can hear them, appreciate their presence, or “want to keep on fighting.” Sometimes these
The family's spoken language and cultural understanding of health, illness, and dying play crucial roles in their ability to meaningfully communicate with ICU staff members. Both literally and figuratively, it is important for families to sense that ICU physicians and staff members are working hard to “speak the family's language.” Translated literally, this means that ICU staff members must ensure that families can understand the content of what the staff are conveying. For families who may not enjoy a medically rich vocabulary, this means avoiding the use of technical terms and medical jargon, and frequently asking if there are questions. Meanwhile, for families for whom English is not their first language, offering and utilizing medical interpreters is extremely important (31). Family members should not be used as interpreters, as it places a major burden on these individuals to remain intellectually engaged in understanding and conveying material and to emotionally cope with the information they are processing. Family members who become the “go-to” person in terms of interpreting may also emphasize certain facts to loved ones in order to influence their decisions or can reluctantly become primary decision makers based solely on their knowledge. Whether a family visit is for, revelations about the individual's developmental level of the child and whether the child could visit the ICU are whether it is appropriate for the developmental principles. 

Thus, it behooves the physician or nurse interested in practicing whole-family care to keep in mind a few development principles. 

The first issues to consider when a family asks about a child visiting in the ICU are whether it is appropriate for the developmental level of the child and whether the child could visit the unit and feel safe, as well as understand the content of the visit. It is thus most important to ask: Whose idea is it for the child to visit, and why? Occasionally, when the staff inquires who the child's visit is for, revelations about the individual's own experience are revealed. For example, one man who was quite emotionally distraught wanted his 4-year-old son to visit his grandmother, who was on a ventilator and likely to pass away. This preschool-aged boy had experienced little contact with his grandmother prior to her illness and had clearly stated he did not want to go. Yet, his father explained to the ICU social worker: “Well, I just think he ought to see grandma. I always wanted to see my grandma and regret it, so I think my son should see hers.” Having made that statement, the man realized that his desire to have his son come to the ICU was a projection of his own wishes to relieve guilty feelings about failing to visit his own grandmother. With the help of the unit social worker, the gentleman and his wife instead opted to have their son stay at home, but were able to learn some simple phrases to explain to this youngster what was going on with his grandmother. 

Meanwhile, there are very good reasons for children to visit loved ones in the ICU. To promote attachment and understanding; to reduce fears, hopelessness, and guilt; and to fulfill a mutual desire on the part of the patient and child to see one another (32). For example, when a child's parent is hospitalized but likely to recover, the child's fears of his mother or father dying or going through immeasurable torment may be assuaged by visiting. The visit may have a dual positive purpose—it may also serve as a means for the child to see his parent and feel safe, as well as understand the content of the visit. It is thus most important to ask: Whose idea is it for the child to visit, and why? Occasionally, when the staff inquires who the child's visit is for, revelations about the individual's own experience are revealed. For example, one man who was quite emotionally distraught wanted his 4-year-old son to visit his grandmother, who was on a ventilator and likely to pass away. This preschool-aged boy had experienced little contact with his grandmother prior to her illness and had clearly stated he did not want to go. Yet, his father explained to the ICU social worker: “Well, I just think he ought to see grandma. I always wanted to see my grandma and regret it, so I think my son should see hers.” Having made that statement, the man realized that his desire to have his son come to the ICU was a projection of his own wishes to relieve guilty feelings about failing to visit his own grandmother. With the help of the unit social worker, the gentleman and his wife instead opted to have their son stay at home, but were able to learn some simple phrases to explain to this youngster what was going on with his grandmother. 

In addition to gauging emotional factors when helping families decide whether a child should visit the ICU, safety factors must also be considered. For example, the child who becomes overwhelmingly anxious, even dangerously hyperactive, is not
a great candidate for visiting the ICU. Also, given their un-
developed immuno-compentence, it is typically considered snap-
prome to restrict access to the ICU for the first few months of life.

Finally, children, adolescents, and families need to be pre-
pared for an ICU visit. This is best done by having a staff
member meet with the child and an accompanying adult family
member to provide guidance about the experience. They need
both an appreciation of what may be seen, felt, and understood
in the ICU, and what consequences may require attention af-

This desire for understanding is balanced with not wanting to
look “dumb,” so school-aged children will often not ask ques-
tions. The key to preparing children of this age for visits with
critically ill relatives and family friends is to provide basic de-
tails about illness and frequently ask if they have any questions.

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The information that follows may be helpful to staff when taking these developmental consider-
ations into account.

**Preschoolers (3- to 6-year-olds)**

There are three features of preschool-aged children that are
central to their visitation to the ICU. The fact that they are egoen-
centric, they employ magical thinking, and they are keenly focused
on body integrity. Regarding the first two points, children of-
ten believe they are responsible for their own illnesses or the
illnesses of loved ones. For example, one little girl believed her
mother was in the ICU because the same day her mother was
hit by a car, she had “said a swear.” With great effort, this little
girl’s father assured her guilt and explained the nature of the
car accident. Meanwhile, remember that children of this age
are very concerned with body integrity; they love bandages,
often believing that “boos-boos” that are not properly covered
will cause the illness to return. Hence, when children see tubes,
catheters, blood-smeared intravenous sites, or wounds, they
can become tremendously fearful. They may also reason that
these things are what is keeping the patient in the ICU and
making him or her ill, as opposed to thinking that the ICU is
keeping the patient there to provide loved ones the necessary
care to keep him or her alive. Providing children with pictures
of what they will see in the ICU—such as showing them an
IV pole, a stretcher, a monitor, and a puppet play about what
the ICU will be like before they visit—can be key to helping
them gain a sense of mastery over their ICU visit. For exam-
ple, after taking a tour of an empty ICU room and being told
what to expect, one proud 6-year-old commented: “My dad
was connected to this bag (IV fluids) on this pole and this ma-
iceine, ’cuz his lither and his kid knees aren’t working, but it
was okay, these machines were helping.”

**School-aged Children (7- to 11-year-olds)**

Around the age of 7, children begin developing a more so-
plicated world view based on logic. They have a voracious
appetite for knowledge and understanding the “rules” of a sys-
tem. For example, first-graders love board games. However,
this desire for understanding is balanced with not wanting to
look “dumb,” so school-aged children will often not ask ques-
tions. The key to preparing children of this age for visits with
critically ill relatives and family friends is to provide basic de-
tails about illness and frequently ask if they have any questions.

Too much information can overwhelm children of this age, who
may still find the internal organ “goings on” of an ill individual
quite mysterious. Helping children gain a sense of mastery by

buying books and using diagrams or models to explain what
is happening to a relative may be very helpful. Finally, giving
children something to do, such as filling a water pitcher or vase,
opening cards, or presenting a gift, can help alleviate boredom
and promote a sense of accomplishment—they will feel like
they have been helpful to the loved one. One last note on chil-
dren of this age is that early in the school-age developmental
era, children gain a sense that death is permanent. This may
bring about a profound anxiety. Exploring children’s thoughts
on the matter and reassuring them that their life routines and
schedules will continue despite the possible loss of a loved one
can be very reassuring.

**Preteens and Adolescents (12+ Years)**

Teenagers have a much stronger sense of medical reality and,
with this understanding, more robust, emotional responses.
Some adolescents may throw themselves into the caretaker role,
wanting to operate on the level of adult family members that are
visiting. Others may choose to avoid the hospital, finding the
experience too overwhelming. Helpful measures can be taken
such as being nonjudgmental, laying out the pros and cons of
visiting relatives, and avoiding “guilt trips” such as “this may
be the last time you ever get to see your uncle so you’d better
get.” Also, when providing adolescents with information before
they come to the hospital, they may be quite offended when
they are “spoken down to”; hence, a very nonauthoritarian,
open discussion of what is happening to their relative or loved
one is the best approach. Finally, it is helpful when communi-
cating with anxious teenagers to ask, in an open-ended man-
er, if there is anything they are worried about. Most teenagers
louthe comments such as “I can see you’re worried. Just ad-
im it,” which can lead to painful arguments during the drive
to and from the hospital. Particularly with teenagers, but also
with younger children, in family conferences, it is important
for doctors and nurses to look them in the eye, shake their
hand, and ask if they have any questions—treating them as full
members of the family.

**SUMMARY**

Mindful practitioners attend in a non-judgmental way to their own
physical and mental processes during ordinary, everyday tasks. This
critical self-reflection enables physicians to listen attentively to pa-

tients’ distress, recognize their own errors, refine their technical
skills, make evidence-based decisions, and clarify their values so
that they can act with compassion, technical competence, presence
and insight.

Ronald Epstein (33)

Care in the ICU requires highly specialized knowledge and skill
on the part of all health professionals. However, the technical
skills required for optimal care may be severely compromised
by the emotional reactions of patients and families. Physicians
in the ICU should see themselves not only in a capacity to cure
or stabilize illness, but also in a unique position to heal. Heal-
ing involves more than applying current scientific knowledge,
diagnostic procedures, and therapeutic technique. Beyond
these critical factors, it requires providing comfort, reassur-
ance, open and honest communication, respect, and empathy
(34). Too often, care is compromised by the interference of
the patient and/or family in the therapeutic process. When
the clinician can appreciate the types of personalities and re-
actions of patients and families in crisis situations, understand the underlying psychological processes that engender them, and maintain an acute awareness of his or her own responses to them, he or she will be fully able to provide the best possible care in the ICU.

Working in the ICU is, of necessity, a multidisciplinary team-
based enterprise. As such, there is no substitute for discussion by team members of both the medical aspects of their patients’ conditions and their emotional reactions, especially as they im-
press individual clinician and team functioning. Being mindful of the constantly changing nature of the situation and of the patient’s condition, the ICU staff should welcome the assistance of consultants and re-
straints in their management of difficult patients. Moreover, the ICU staff might also want to welcome the assistance of consultants and mentors with extensive experience in their management of dif-
ficult patients and families.

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