

DEPENDENCY, PSYCHOPATHOLOGY, AND DIFFICULT DOCTOR-PATIENT  
RELATIONSHIPS IN PRIMARY CARE PATIENTS

By

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**TITLE** DEPENDENCY, PSYCHOPATHOLOGY, AND DIFFICULT DOCTOR-PATIENT RELATIONSHIPS IN PRIMARY CARE PATIENTS

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## **Chapter 1**

### **Introduction**

Having a strong doctor-patient relationship and working alliance can have much to do with the outcomes of healthcare. Peabody (1927, pg 877) stated that “the practice of medicine in its broadest sense includes the whole relationship of physician with his patient”. Fuertes, Mislowack, Bennett, Paul, Gilbert, and Fontan (2007) found that physicians with a warm friendly style are more effective than physicians with a more formal style. Bennet, Fuertes, Keitel, and Phillips (2011) found that in a group of lupus patients, the working alliance between the physician and the patient was significantly and positively related to the patient adhering to the recommendations, the patient’s satisfaction with the healthcare, and the quality of life for the patient. This suggests that a strong relationship between the physician and the patient can increase the treatment effectiveness and result in better outcomes. Overall patient satisfaction, treatment adherence, and treatment outcome have been found to be associated with the doctor-patient relationship (Marukn, Garske, & Davis, 2000; Fuertes et al., 2007; Griffith, 1990).

Dissatisfying relationships between doctors and their patients can have significant emotional, financial, legal, and ethical consequences (Schwenk & Romano, 1992). The successful use of management strategies depends upon how willing the physician is to see the difficult relationship as being created by both the physician and the patient. One of every six patients, or 11% to 20% of patients, are experienced as being difficult (Hahn, Kroenke, Spitzer,



Brody, Williams, Linzer, & deGruy, 1996). Difficult patients are thought to be high utilizers of health care services, dissatisfied with the care that they receive, contribute to physician burnout and dissatisfaction, and overall have poorer treatment outcomes (Porcerelli, Bornstein, Markova, & Huprich, 2009). The health care sector is concerned that the patients' care may suffer since they are less likely to follow through with recommendations from their physician due to being dissatisfied. Resources may be misutilized as well because the reaction of the physician (i.e., distancing themselves from the patient) may interfere with the delivery of compassionate and appropriate, care leaving the patient to seek out second and third opinions (Hahn, Thompson, Wills, Stern & Budner 1994). Physicians become unenthusiastic about providing care to difficult patients since they find these patients frustrating and time consuming (Hahn et al., 1994). In addition, physicians report feeling ill at ease with difficult patients and feeling as if they are being manipulated. This often results in the physician wishing that the patient not return (Hahn et al., 1996).

Specifically, Axis I pathology has been linked to physicians experiencing the patient as difficult. Difficult patients are almost twice as likely to have an Axis I diagnosis (67% vs. 35%) (Hahn et al., 1996). In addition, certain pathological personality characteristics of the patient have been associated with difficult doctor-patient relationships (Walker Katon, Keegan, Gardner, & Sullivan, 1997).

Dependency is a personality characteristic that has been shown to have important implications for physical health and health care utilization. Dependent patients have a greater number of pseudoemergencies than nondependent patients, and they use significantly more

psychological and medical resources than the less dependent patients (Emery & Lasher, 1982; O'Neil & Bornstein, 2001).

However, dependent individuals have been shown to react in ways that are positive in some situations as well. For example, dependent females have been shown to be more accurate in their perceptions of social situations than nondependent females (Masling, Johnson, & Satruransky, 1974).

In addition, Bornstein (1992) stated that research has led to the conclusion that dependent people are more interpersonally sensitive. This led to the hypothesis that there may be a continuum of dependent personalities with Destructively Overdependent people lying on one end, healthy dependent people in the middle, and Dysfunctionally Detached individuals on the other end. In the creation of the Relationship Profile Test, Bornstein and Languirand (2003) separated people into these three different groups. Those individuals who have dependent characteristics, but who use these in a more adaptive way were termed Healthy Dependent individuals. These would be the individuals who are able to form accurate perceptions in social situations and possess good levels of interpersonal sensitivity. Those who were dependent, but used these characteristics in a less adaptive way were termed Destructive Overdependent. Those individuals who were the complete opposite of Destructive Overdependent were called Dysfunctionally Detached.

Bornstein (1995, 2003) found that interpersonal dependency predicts health status and health service use. Destructively Overdependent individuals are more likely to have mild short-term illnesses as well as more serious illnesses like heart disease and cancer. In addition, they make more visits to their health care providers, have more pseudoemergencies,

and make more requests for between session contact with their physician (Emery & Lasher, 1982). Destructively Overdependent individuals also tend to receive more psychotropic medications and non-psychiatric medical consultations than those who are nondependent (O'Neil & Bornstein, 2001). Porcerelli, Bornstein, Markova, and Huprich (2009) also found that Destructive Overdependent individuals have a significantly greater outpatient and average healthcare costs compared to non-dependent individuals. Porcerelli, et al. (2009) found that the individuals who were Dysfunctionally Detached were similar to the Overdependent individuals in that they tend to be higher utilizers of health care and have more medical diagnoses. It was also found that these individuals have the highest average cost per visit, which they suggested was due to the fact that these individuals might delay treatment because they deny needing help. Haggerty, Blake, and Siefert (2010) also found that those who are Dysfunctionally Detached report lower psychological health and well-being. In contrast, those individuals who are classified as being Healthy Dependent have fewer medical diagnoses, and it has been suggested that these individuals are capable of forming good working relationships with their physicians, are capable of following through on the recommendations made by their physicians (i.e., depend on their physician's advice), and call on healthcare providers when it is necessary (Porcerelli et. al., 2009).

### **Purpose**

The present study incorporated physicians' ratings of their experiences with patients to examine the relationship between difficult doctor-patient relationships, patient psychopathology, pathological dependency, years the physician has been practicing medicine, and the patient's overall health status. It also included ratings of the patient's

experiences with their physicians to examine the relationship between patient psychopathology, pathological dependency, years of practice by the physician, and the patient's overall health status. This study had two primary objectives: a) to understand the relationship between patient depression, anxiety, detachment, dependency, number of years the physician has been practicing medicine, and the patient's overall health status with the physicians' rating of perceived difficulty when working with a patient and b) to understand how the relationship between patient psychopathology, detachment, dependency, years the physician has been practicing medicine, and the patient's overall health status with the patient's rating of the relationship with their physician. It was expected that patients being destructively overdependent or dysfunctionally detached would significantly and incrementally add to the variance accounted for in rating of difficulty in working with a patient beyond what has been shown to be accounted for by Axis I pathology. In addition, the number of years the physician has been practicing medicine and the patient's overall health score were expected to add to the variance of these variables. The ratings of difficulty provided by the patient have not been studied to the same extent that difficulty ratings provided by the physician has. It was expected that Axis I pathology, patient Destructive Overdependence, patient Dysfunctional Detachment, the patient's overall health score, and the number of years of physician training would be significantly related to patients' ratings of difficulty in working with their physician. It was also expected that these variables would be significant predictors of the patients' ratings of perceived difficulty.

There are several reasons for conducting this study. Stanton (2002) explains that recently the healthcare costs have been greatly inflated, and that policymakers are now

searching for ways to decrease these costs without reducing access to healthcare or creating burdens for the providers. Because of the emphasis on reducing health care costs, it is important to better understand the relationship between difficult doctor-patient relationships with dependency and detachment which have both been shown to be related to higher costs and utilization. In addition, patients who are considered difficult or rate themselves as being overdependent or detached are more likely to perceive their medical visits as being unsatisfactory (O'Neil & Bornstein, 2001). In order for patients to continue their medical care, it is important that they feel physicians are there to help them. Further understanding the predictors of a difficult doctor- patient relationship will help to educate physicians on factors that contribute to developing a difficult relationship with their patients, so that they might be able to help improve the quality and outcome of healthcare.

## Chapter 2

### Review of Literature

#### Difficult-doctor patient relationships

One third of all patients are considered by physicians to be self destructive or difficult to communicate with (Hahn et al., 1996). Not only do the physicians perceive these patients as being difficult to work with, the patients often are dissatisfied with their care. Hahn et al. (1996) found that patients who were experienced as difficult reported on average 2.4 visits to their physician in the preceding three months and 0.49 emergency department visits. In contrast nondifficult patients reported 1.5 visits to their physician and 0.25 emergency room visits during the same time period. In addition, difficult patients report nearly three times as many disability days in the last 3 months (11 vs. 4). When adjusting for patient characteristics including psychiatric comorbidity difference in visits between the difficult and nondifficult patients remains significant. Jackson and Kroenke (1999) looked at the time period between three months before and three months after the walk-in visit. The patients rated by the physicians as being difficult made 4 visits in the following 3 months whereas the patients who were not perceived as being difficult made 2. During the entire six month period the difficult patients made 5.5 visits whereas the nondifficult patients made 4.0 visits, which was found to be significantly different ( $p = .05$ ). Difficult relationships are also associated with two to three times higher rates of radiographs, laboratory tests, and physician referrals (Schwenk & Romano, 1992). Referring patients to certain specialty doctors can lead to a loss of continuity of care, lead to tests being repeated, and increased physician time being

required for new patients. The patient's trust must be reestablished with each new physician (Schwenk & Romano, 1992).

Hahn et al. (1994) found that 98% of physicians dealing with difficult patients had "physician dysphoria," reflecting a negative emotional response to the difficult patients. It has been suggested that the physician experiences grief because they mourn the loss of a satisfying relationship in which the physician is able to perform a valued service and the patient is involved and satisfied (Schwenk & Romano, 1992). In addition Schwenk and Romano (1992) explain that these difficult relationships can also cause the physician to feel frustrated, angry, and inadequate, and cause the physician to blame the patient for the problem. It was suggested that some physicians experience difficult patients as not being worthy of attention due to the distress they cause the providers (Jackson & Korenke, 1999). Patients who are experienced as difficult may represent a population with negative healthcare outcomes that may require special management.

Groves (1978) identified four personality styles that he termed the "hateful patients." The first personality type is called the "dependent clinger". These are patients whom he described as being bottomless pits of neediness. They overwhelm the physician with multiple problems that have no solution. The patient escalates from mild and appropriate requests for reassurance to repeated cries for an explanation, affection, analgesics, sedatives, and attention. These patients use flattery and unconscious seduction in order to elicit what they want from their physician. The patient's perception is that the physician is inexhaustible. This may lead the physician to experience aversion to that patient. Often, when the physician

becomes exhausted they provide a referral to a psychiatrist, and the patient correctly perceives this as a rejection, so the referral often fails. Early signs that a patient is a dependent clinger include the patient's genuine gratitude, but it is expressed in an extreme degree. The doctor will initially experience feelings of power and specialness with the patient. However, the dynamics of the relationship change over time with the doctor playing the role of an inexhaustible mother and the patient becomes the unplanned, unwanted, and unlovable child. Groves (1978) indicates that these patients must be told early on in a tactful firm manner that the physician not only has human limits to knowledge and skill, but also limitations when it comes to time and stamina.

The second personality he called the "help rejecting complainer" (Groves, 1978). These are the patients who demand relief from their problems, but they create frustration for the physician because when they are offered solutions, they find them inadequate or harmful. They are different from the dependent clinger because they do not even try the solution the doctor offers them for their problems. These patients seem to have unending need for emotional supplies. They appear to feel that no regimen will help them, and they will return numerous times to report that the regimens suggested did not work. When one symptom is relieved another one will appear. What these patients are seeking is not relief from their symptoms but an undivorceable marriage with an inexhaustible caregiver. In addition these patients will typically refuse a referral to a psychiatrist. Their manipulateness is a covert, contradictory, self-defeating attempt to get their needs met. Groves (1978) advises physicians to convey to the patient that they will not be allowed to become so close as to be engulfed or so distant as to starve. Groves (1978) also suggests that



the patient will be more likely to follow through with a psychiatric referral and less likely to perceive this as abandonment if there is a follow up visit with the primary care physician shortly after their visit to the psychiatrist.

Groves (1978) termed the third personality the “entitled demander.” These patients angrily insist on things and then try to intimidate the physician to ensure that they get them. The physician feels fear and anger which then turns toward guilt and shame. These patients resemble the dependent clingers because of their neediness, but instead of using flattery and unconscious seduction, they use intimidation, devaluation, and guilt to place the doctor in the role of the “inexhaustible supply depot”. They may attempt to control the physician by withholding payment or threatening litigation. Their hostility reflects their fear of abandonment.

The patient’s sense of innate deservedness and acting as if superior to the physician, protects them from the awareness that the physician seems to have power over life and death. Groves (1978) suggests that the physician can deal with these patients by acknowledging that the patient has a right, not to unreasonable demands or to bully others, but to what is realistically good care. However, the physician also needs to be cognizant of getting entangled in complicated debates.

The final personality Groves (1978) described was the “self destructive denier.” These patients cause the physician to feel helpless and guilty because they elicit and then frustrate the physician’s efforts to change the patient’s self-destructive health behaviors. These patients are extremely dependent and have given up hopes of having their needs met. They may appear to be getting pleasure by defeating the physician’s attempts to preserve

their lives. Groves (1978) states that the physician must first recognize that the patient provokes in them a wish that the patient would die and get it over with. If the physician is more reflective, these feelings may be conscious and be recognized without shame or self guilt. However, if the physician is unreflective, these feelings may be hidden and cause the physician to feel dread, self-blame, or a flat bland, given-up and hopeless attitude. Optimal care for these patients would include a visit to a psychiatrist to screen for underlying depression. However, if the patient refuses, the physician must fight the impulse to abandon the patient and recognize the limitations that these patients pose. Groves (1978) states that the doctor's ideal is to "know all, love all, and heal all", but this becomes difficult for them when they encounter sick and troubled patients. This can result in the physician experiencing helplessness, unconsciously punishing the patient, inappropriate confrontation of the patient, and desperate attempts to avoid or to extrude the patient from the care giving system (Groves, 1978).

Schwenk, Marquez, Lefever and Cohen (1989) found that patients with abrasive behavioral styles were a major determinant of physician experienced difficulty when they asked physicians to rate the patient that was the "most difficult that day." Merrill, Laux, and Thornby (1987) also found that the patient's having an abrasive personality style and multiple symptoms consistently generated negative feelings in physicians. However, when the physician had low self esteem, they were particularly vulnerable to experiencing patients as difficult.

Schwenk and Romano (1992) also categorized several personality types of patients that would contribute to a difficult doctor- patient relationship. The first of these is the *passive- dependent over-demanding patient category* whose expectations for physician time and expertise exceed the physician's capabilities. The second is the *dramatic emotionally involved, seductive affectionate patient category* whose need for attention exceeds the physician's time and energy. The third is the *long-suffering masochistic denying patient category* who has a need to maintain their sickness. The fourth is the *somatizing patient category* who challenges the physician with seemingly endless variety of hypochondriacal and somatic complaints. The final patient they describe is the *angry demanding complaining patient category* whose expectations and methods of expressing them can offend the sensibilities and threaten the autonomy of the physician. This model is only slightly different than the model Groves (1978) proposed. Schwenk and Romano (1992) maintained the same four types of patient that Groves (1978) did, but they added the somatisizing patient category that Groves (1978) did not list in his model.

#### *Factors associated with difficult doctor- patient relationships*

Several factors have been hypothesized as contributing to a physician perceiving a patient as being difficult to work with. Goodwin, Goodwin, and Kellner (1979) studied a sample of patients with systemic lupus erytogenatosis, and found that those patients with anxiety, hostility, depression, and organic impairment of mental status were the most disliked by their physicians.

Novack and Landau (1985) evaluated perceived problem patients in a medical psychological consultation clinic. Patients were categorized as being difficult if their

physician described them as such and there was also a history in their charts of backing up this description. Of these 52 patients, 49 of them had symptoms meeting criteria for a DSM-III diagnosis. Thirty-one percent of the patients had a Psychogenic Pain Disorder, 17% had Conversion Disorder, another 17% had Panic Disorder, and 15% had Major Depressive Disorder.

Lin, Katon, Von Kroff, Bush, Lipscomb, Russo, and Wagner (1991) studied patients in a health maintenance organization program who were viewed as being frustrating by their doctors. The physician's rating of the patients physical disease was not different for the patients they viewed as frustrating versus the patients they did not experience as frustrating. In addition, the patients who were experienced as frustrating rated their own health as being worse than did the patients who were viewed as not frustrating, and the frustrating patients also had more somatic symptoms and disabilities than the nonfrustrating patients. The group of frustrating patients also utilized the medical services more than the non-frustrating patients. While all groups had an equal prevalence of mental disorders, the frustrating patients had higher rates of somatization and generalized anxiety disorder.

Sharpe, et al. (1994) studied difficult doctor-patient relationships within two medical clinics and one surgical clinic. The physicians rated 22% of the patients as being severely or extremely difficult to help. Difficulty in helping patients was associated with greater patient distress, less patient satisfaction, and repeated appointments. Sharpe et al. (1994) interviewed 40 of the difficult patients, and it was found that these difficult patients indicated that they felt their current physicians considered psychosocial factors more important to discuss than other previous physicians. It was also found that in those doctor-patient encounters with a

more difficult patient there were more objective differences between the doctor's aims for the patient's care and the patient's aims for their own care. There were three common types, those with: 1) medically unexplained symptoms, 2) co-existing social problems, and 3) severe untreatable illness. The patients who were rated more difficult to help had higher scores on anxiety and depression.

Schwenk, Marquez, Lefever, and Chen (1989) assessed perceived difficulty with patients who were seen by family physicians. Physicians rated 40 different behavioral and physical characteristics of difficult patients. There were two factors that emerged from a factor analysis that were underlying the physicians' perceptions of difficult patients, 1) medical uncertainty and 2) interpersonal difficulty. Medical uncertainty is characterized by the patient having vague, difficult to describe, undifferentiated medical problems. Interpersonal difficulty reflects the physician perceiving the patient to have an abrasive behavioral style.

The Difficult Doctor Patient Relationship Questionnaire (DDPRQ) (Hahn, Thompson, Wills, Stern, & Budner, 1994) was developed to understand difficult physician-patient relationships as rated by the physician. The measure is composed of 30 likert items, which are completed by physicians after their encounter with the patient. The physician rates each item from 1 to 6 for a total possible score of 180. In order for a patient to be considered "difficult" the total score must be 90 or above. The DDPRQ-10, a shorter form of the DDPRQ, was developed by Hahn, Kroenke, Spitzer, Brody Williams, and deGruy (1996). The short form contains a total of ten likert items, which are rated by the physician after their encounter with a patient. Each item can be rated from 1 to 6 for a total possible score of 60.

Any score of 30 or above is considered indicative of a difficult patient. Hahn et al. (1996) used the DDPRQ-10 and found that patients who were not at all known by the physician before the appointment were less likely to be experienced as difficult than those patients who were somewhat known and well known to the physician. Walker, Katon, Keegan, Gardner, and Sullivan (1997) studied patients in a rheumatology clinic with either fibromyalgia or rheumatoid arthritis. The DDPRQ was used to understand which factors were best associated with physician's experiencing the relationship between themselves and their patients as difficult. Patient variables that were found to be associated with the physician perceiving the relationship as difficult were marital status (those who were single were perceived as more difficult), current dysthymia and agoraphobia, lifetime Panic Disorder and Obsessive-Compulsive Disorder, adult rape and physical abuse, somatization disorder, physical and social disability, the presence of fibromyalgia, neuroticism, illness impact, and perceived loss of control. The best model for predicting the degree of frustration included the patient's having somatization disorder, perception of a lack of control over their illness, and a lifetime history of Obsessive-Compulsive Disorder. Together these three variables accounted for 48% of the variance in the DDPRQ scores. The physicians in this study were most frustrated with their patients who had ongoing preoccupation with multiple medically unexplained physical symptoms. Hahn et. al. (1996) added the DDPRQ-10 (a short form of the DDPRQ) to the PRIME-MD 1000 study (Spitzer et. al., 1994) and administered it to the physicians of 627 of the 1000 patients in the study. There was no univariate association between the DDPRQ-10 scores and the demographic variables. Of these, 155 of the patients were experienced as difficult using the cut off score of 30 out of 60. It was found that physician familiarity with

the patient had an influence on whether the physician experienced the patient as difficult or not. The patients that were not at all known before to the provider were less likely to be experienced as difficult. The reason behind this is not known, but it is suspected that as the physician has continuous visits with a patient, they are more able to see the patient's symptoms of a mental disorder, a personality disorder, and whether or not a patient follows through on the recommendations provided by the physician. These things would not be as obvious to a physician who is seeing a patient for the first time.

Schwenk and Romano (1992) explain that many patients who are experienced as difficult by the physician have undiagnosed mental illnesses that can affect the patient's ability to communicate. These mental illnesses may also underlie a wide variety of symptoms like fatigue, chest pain, and neurologic complaints.

Twenty-five percent of patients with mental disorders are experienced as difficult compared to 8.5% of patients without mental disorders. Hahn et al. (1996) found that of the 252 patients with mental disorders in this study 25% were rated as being difficult compared to only 8.5% of the patients without mental disorders. Difficult patients have an average of 1.8 mental health diagnoses whereas non difficult patients have a mean of 0.7 mental health diagnoses (Hahn et. al., 1996). In addition, physician experienced difficulty increased with the severity of mental disorders present. The scores are highest on the DDPRQ when patients meet criteria for a DSM diagnosis, and they decrease in a step like fashion when patients have subthreshold, psychiatric symptoms but no diagnosis, followed by patients without a psychiatric disorder (Hahn et al., 1996). There were 11 different psychiatric diagnoses that occurred in at least 4% of the patients included in the sample. Six of these were associated

with an increased risk for being experienced as difficult; multisomatoform, dysthymic, generalized anxiety, major depression, panic disorders, and probable alcohol abuse or dependence.

Jackson and Kroenke (1999) also found that the presence of either a mood disorder or anxiety increased the likelihood that physicians would experience their patient as being difficult. Walker et al. (1997) found that in patients with fibromyalgia and rheumatoid arthritis, the DDPRQ scores were correlated with the presence of current dysthymia and agoraphobia as well as a lifetime prevalence of panic, obsessive compulsive disorder, and somatization disorders. Hahn et al. (1994) found that 77% of difficult patients met criteria for at least mild psychopathology compared to the 28% of non difficult patients. They also found that the total number of charted psychiatric diagnoses was significantly associated with the DDPRQ score. Half of all difficult patients had at least one active psychiatric diagnosis whereas only 26% of the non difficult patients had at least one. In addition the severity of the patient's psychopathology was positively correlated with the DDPRQ score. Hahn et al. (1994) also looked at the charted psychosomatic symptoms. Symptoms were labeled as psychosomatic if the physician explicitly labeled them to be or if judged as unexplained by diagnosis in the chart. The total number of the symptoms was counted over a three year period yielding a score from 0 to 9. The total number of somatic symptoms was significantly correlated with the DDPRQ score. Hahn et al. (1996) found similar results. The patients with one or more psychosomatic diagnoses such as irritable bowel syndrome, migraine, and pain that were explicitly labeled as psychosomatic by the physician had higher DDPRQ scores than those patients without these diagnoses.



Hahn et al. (1996) found that the total number of physical symptoms and the number of the symptoms judged as being somatoform both correlated with patient being perceived as being difficult. However, upon further investigation there was no association between difficulty and the presence of any of the most common medical disorder such as hypertension, arthritis, diabetes, cardiac disease, pulmonary disease, or cancer. Alternatively, the DDPHQ-10 scores, showed that physicians experiencing their patients as difficult was related to the number of symptoms that were judged by the physician to be somatoform and functional disorders like irritable bowel syndrome, tension headaches, fibromyalgia, and premenstrual complaints. In Jackson and Kroenke (1999), the presence of 5 or more of the 15 symptoms on the PRIME-MD patient questionnaire was associated with an increased likelihood that the physician would experience the patient as being difficult. Patients, who reported the severity of their symptoms to be 6 or greater on a 10-point scale, were more likely to be experienced by the physician as being difficult.

Walker et al. (1997) assessed patient personality characteristics in comparison to the DDPHQ-10 scores. They found that a scale that assessed worry, tension, loneliness, and helplessness were positively correlated with the DDPHQ-10 scores. In addition the patients who perceive a loss of control because of a chronic illness are more likely to be experienced as difficult by their physicians. Hahn et al. (1994) found that 99% of the patients who are described as demanding and irritating by their physician have significantly high ratings on the DDPHQ by their physician. Hahn et al. (1994) found that 44% of patients identified as difficult in their sample met criteria for a personality type (did not meet criteria for a diagnosis of a personality disorder but had features) and 12% for a personality disorder.

Jackson and Kroneke (1999) found that the prevalence rate of patients who were experienced as difficult in a walk in clinic was 15%. However, in this setting physicians would not have built a long standing relationship with their patients. It has been found that in other settings that 10-20% of the doctor-patient relationships can be meaningfully characterized as “difficult” (Hahn et al., 1994). Hahn et Al. (1994) found that 20% of patients in a primary care sample had DDPRQ scores that would categorize them as being difficult, but when the patient was required to actively participate in the study by completing measures only 11% of patients were rated as difficult. This suggests that the difficult patients may not volunteer to participate when they are required to actively participate by completing questionnaires themselves. Hahn, Kroenke, Spitzer, Brody, Williams, Linzer, and deGruy (1996) found that 15% of the patients in their primary care patient sample were rated by physicians as being difficult. However, among the four different sites used in their study, prevalence rates of patients rated as difficult ranged from 11- 21%. Hahn et al. (1996) suggest that it would be noteworthy to look at the referral rates made, medication use, laboratory testing, as well as procedure rates and complications with these patients who are perceived as being difficult in a primary care setting. This would allow for a better understanding of how recommendations, treatment plans, utilization of healthcare resources, and costs of medical procedures are affected when a physician perceives their patient as being difficult.

Schwenk and Romano (1992) suggest that there may also be technical barriers encountered in a health care setting like communication barriers or conversation styles, memory impairment or cognitive deficiency, inadequate time or privacy, physician

personality disorders, and physician fatigue or distraction, which may contribute to a difficult relationship between a physician and a patient. There could also be topics or issues that the patient finds difficult or uncomfortable to discuss such as sexual concerns, abuse, family secrets, terminal care issues, disagreement with the physician's recommendations, and a desire for a second opinion, that could add to a difficult relationship. This can work both ways too. There might be topics that the physician finds difficult or uncomfortable to discuss such as abuse, sexual paraphilias, and disagreement with a previous physician's recommendations that could contribute to a difficult relationship (Schwenk & Romano, 1992). In addition physician's expectations may not be met by the relationship with the patient or the norms may be challenged by the patient's behavior. Schwenk and Romano (1992) explain that physicians have a desire to be needed by the patient and gain satisfaction from providing care, a sense of closure and satisfaction with their recommendations, and a patient who is cooperative and appreciative. The physician may become frustrated when patients question their recommendations, make specific suggestions about tests or treatment, and quote specific medical recommendations from lay publications. Physicians also bring familial, cultural, religious, social, ethnic, and racial norms and values to the relationship (Schwenk & Romano, 1992). It is also reasonable to assume that the physician having either a DSM Axis I or Axis II disorder could also contribute to a difficult doctor-patient relationship.

Hahn et al. (1994) suggests that difficulties may come from a unique juxtaposition between particular provider and patient characteristics including communication patterns, physician characteristics, patient characteristics, psychopathology and especially undetected

psychopathology. They computed a difficulty characteristic score. Somatization was included if the patient had four or more psychosomatic symptoms. Physician-detected psychological problems were positive if there was clinically significant psychopathology noted by the physician. Charted psychiatric diagnoses were treated as positive if any were present in the patient's chart. They also included the general health questionnaire and personality traits. Then they came up with a total score for all the difficult characteristics a patient exhibited. The patients who were rated as being difficult by their physician when using the DDPRQ had a mean of 3.3 difficult characteristics whereas the patients not rated as difficult had a mean of 1.1 characteristics. Eighty-nine percent of the difficult patients had two or more of the characteristics versus 29% of the patients rated as not difficult had two or more characteristics. The difficult doctor-patient relationship was independent of the total number and most types of Axis III medical diagnoses, patient age race, gender, and marital status, and the type and gender of the clinician. The characteristics that are found to be associated with difficult relationships tend to be manageable when they appear alone, but when several are present in an individual patient, then the relationship is one that is rated by the physicians as being difficult. This suggests that when a physician encounters a more complex case where a patient has multiple complaints, the physician is more likely to experience the patient as being difficult.

It seems that patients being experienced as difficult is multifactorial. Hahn et al. (1996) attempted a stage forward regression. In the first step they included patient demographics, clinical site, and physician's familiarity with the patient. This accounted for 4.8% of the variance in the DDPRQ scores. In the second stage they included the 6 difficult

diagnoses and other patient characteristics that had a significant univariate association with the difficulty score. This showed that the number of mental disorders, the number of somatoform disorders, probable alcohol abuse or dependence accounted for 23% of the variance. The presence of the other 4 diagnoses made no additional contributions. In the third step the physicians' ratings of themselves as being interested or not interested in psychiatric diagnoses explained an additional 5.6% of the variance. Collectively they were able to account for 33% of the variance in this model. Jackson and Kroenke (1999) used a logistic regression to examine the variables that predict whether or not a patient was perceived as difficult by their physician. They found that four variables were associated with the experience of the patient as being difficult as measured by the DDPRQ; the presence of a mood or anxiety disorder, five or more physical symptoms, self rated symptom severity of 6 or higher, and negative physician attitude toward working with patients with psychosocial issues. Altogether they were able to account for 34% of the variance, which is rather small.

On the Medical Outcomes Short-Form Health Survey (Carver, Chapman, Thomas, Stadnyk, & Rockwood, 1999) (SF-20), the difficult patients scored from 9 to 22 points lower than non-difficult patients, which indicate difficult patients have greater functional impairment following treatment. This difference remained significant when adjusting for physical illnesses, gender, minority status, level of education, age, clinical site, and familiarity with the physician. However, after correcting for the number of mental disorders, only the pain scale remained significant between the difficult and non-difficult patients on the SF-20. This suggests that most of the functional impairment besides pain experienced by

the difficult patients can be accounted for by their associated mental disorders (Hahn et al., 1996)

Hahn et al. (1996) also looked at patient's satisfaction. Of the patients experienced as difficult, 52% rated the care they had received in the past three months as excellent and 15% rated it fair to poor. In contrast 79% of the non difficult patents rated the care they had received in the past three months as excellent, and 6% of these patients rated it as fair to poor. Jackson and Kroenke (1999) found significantly more difficult patients to be somewhat or very dissatisfied with physicians' technical competence, bedside manner, explanation of treatment, and time spent with the physician, although there was no objective difference in the length of the visits observed. Also, patients who were experienced as difficult were more likely to have unmet expectations for care immediately and two weeks after the walk-in visit.

A self-report instrument has been constructed to assess how the patient feels about the relationship they have with their physician called the Patient-Doctor Relationship Questionnaire-9 (PDRQ-9; Van der Feltz-Cornelis, Van Oppen, Van Marwijk, De Beurs, & Van Dyck, 2004). This measure was developed because both patients and physicians can contribute to the difficult doctor-patient relationship. The questionnaire's items were based off of the helping alliance questionnaire which was developed to examine how the patient in a psychotherapy session feels about their relationship with their therapist. Van der Ferltz-Cornelis et al. (2004) emphasize that aspects of the doctor-patient relationship share certain aspects (i.e. high levels of trust, helpfulness, empathic listening, and interpersonal openness) with the Helping Alliance in psychotherapy. To develop the Patient-Doctor Relationship Questionnaire- 9 (PDRQ-9) the Helping Alliance Questionnaire Dutch Version was used as a

starting point. While there has been a validation study, there have not been any studies to this point that use this questionnaire to better understand what factors play a role in creating a difficult doctor-patient relationship. Van der Ferltz-Cornelis et al. (2004) state that most of the literature that looks at the doctor-patient relationship looks at it from the physician's viewpoint. However, Hahn et al. (1996) showed that difficult relationships are not just experienced by the physician and created by the patient, but they are also experienced by the patient and can be created by the physician.

Van der Ferltz-Cornelis et al. (2004) states that a great deal of literature focuses on the communicative aspect of the doctor-patient relationship through qualitative designs that describe the positive role of affective behavior by the physician and communication models. Through these studies that doctor-patient relationship was explored in terms of its therapeutic effect and the patients' expectations of their physician. It has been found that patients will seek out a primary care provider who matches the representation they have of an ideal physician and will validate their choice in a dynamic communicative process (Bensing, 1991; Van Dulmen, Verhaak & Bilo, 1997; Gore & Ogden, 1998). In addition, studies have identified that deficits in the physician's communication with the patient contribute to difficult doctor-patient relationships. Physicians with more open communication styles that invite their patients to participate have fewer malpractice claims (Jackson, 2005). Better communication skills are also correlated with higher rates of compliance (Hall, Roter, & Katz, 1988). Jackson (2005) found that often the patient and the physician disagree on whether or not the physician discussed the patient's diagnosis and prognosis during their visit. When the patient feels that this has been done they are more likely to be fully satisfied

with the care they receive, less likely to have post-visit worry that their symptom could be due to something serious, and less likely to have other unmet expectations. Physicians must learn the communication skills necessary when working with patients, and it is likely that the physicians who have more experience in treating patients will be able to communicate in a more effective manner with their patients.

Van Walsum, Lawon, and Bramson (2004) found that the physician's relationship with their family makes a difference in their work with their patients. They also suggest that the physician needs to learn to grapple with their own anxiety and the ways that they can best manage it. They highlight the fact that personal matters are translated into the physician's professional activities.

Hinchey and Jackson (2011) used walk-in primary care encounters to look at predictors of difficult doctor-patient relationships. They found that it was both the patient and the physician that contribute to the difficult relationship even though it is the physician who is assigning the label of "difficult" to the encounter. They found that the patients having more physical symptoms, worse functional status, higher utilization, greater symptoms of severity, and were more likely to have underlying psychiatric disorders were more likely to be perceived as difficult. However, physicians who had worse psychosocial attitudes and less clinical experience were involved in a greater number of difficult encounters.

Thornton, Powe, Roster, and Cooper (2011) looked at the social characteristics, like race, age, gender, and education, of both the physician and the patient to see if the physician and the patient sharing similar characteristics would affect the communication and the patients' perception of health care. They found that when the physician and patient had low



concordance among these variables, the patients had less positive perceptions of their care as well as lower positive patient affect. It is important to remember when looking at difficult doctor-patient relationships that it is not just characteristics of the patient that create a difficult relationship, but instead it is the characteristics of both the physician and patient that lead to a difficult relationship.

Schwenk and Romano (1992) explain that once physicians are aware that the relationship between themselves and their patients are difficult, there are a variety of strategies they can employ to improve the quality of the relationship between them and their patient as well as the quality of care. First they suggest that the physician clarify their professional feelings about their patient. All patients deserve positive regard and to be treated with dignity, respect, and kindness. If the physician is unable to provide this, they should consider transferring the patient (Schwenk & Romano, 1992). The second strategy they propose is to use precise and effective communication and interviewing techniques. Having training in psychosocial dimensions can lead to clinical improvements in functional outcomes. It may be useful to use reassurance for patients who somaticize (Schwenk & Romano, 1992). In addition the physician should keep in mind there may be undiagnosed mental illnesses present in their patients. If the physician suspects that there is a personality disorder, they should consult with a colleague in behavioral health to accurately identify the personality style and develop the appropriate interventions (Schwenk & Romano, 1992).

Schwenk and Romano (1992) also suggest that when the physician is working with the dramatic, seductive, emotionally involved, affectionate patient the physician should remember that their seductiveness is a symptom of neediness and asking for support. They

also stress that it is important that the physician learn to set limits with these patients in an explicit non-punitive way. It is okay for the physician to tell the patient that their comments make them feel uncomfortable and redirect the visit back toward the medical issues.

### *Dependent Personality*

Western societies place value on a person being self-sufficient and self-reliant, while having excessive interpersonal dependency has long been viewed as signs of weakness and immaturity (Neki, 1976; Bornstein & Hupirch, 2006). However, humans have a fundamental need to relate to others. Some degree of interpersonal dependency that is expressed in flexible, socially appropriate ways can be adaptive in many contexts (Bornstein, 1998). The adaptive form of dependency has been referred to as interdependence, mature dependency, connectedness, relatedness, and healthy dependency (Bornstein & Huprich, 2006).

Also, Birtchnell (1988) suggested that individuals may be dependent upon others to fulfill different psychological resources for them including identity, instruction, guidance, affection, and acceptance. These individuals are usually submissive and likely to evoke dominant behaviors like guidance and instruction in return (Pincus & Gurtman, 1995).

The DSM-IV-TR Axis II is concerned with diagnosing personality pathology. When personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress they constitute a personality disorder (APA, 2000). Ultimately personality disorders represent for the most part maladaptive variants of the traits that are evident in most people to a lesser degree (Widiger & Costa, 1994).

The DSM-IV-TR's (APA, 2000, pg. 723) has set criteria for the diagnosis of dependent personality disorder. They are as follows:

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following

- 1) Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
- 2) Needs others to assume responsibility for most major areas of his or her life
- 3) Has difficulty expressing disagreement with others because of fear of loss of support or approval. Note: Do not include realistic fears of retribution
- 4) Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
- 5) Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
- 6) Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
- 7) Urgently seeks another relationship as a source of care and support when a close relationship ends
- 8) Is unrealistically preoccupied with fears of being left to take care of him or herself.

Dependent personality is common in inpatient psychiatric settings (15-25%), but is not as high in a large-scale community setting (0-10%). It is also slightly more common in women (11%) than in men (8.5%) (Bornstein, 2005).

### *Dependency Theoretical Models*

Dependency can be used to describe specific behaviors in a particular setting, the current psychological state of an individual, a personality trait demonstrating cross-situational consistency and temporal stability, a personality type that may be vulnerable to psychopathology, or a disorder of personality (Pincus & Gurtman, 1995). There are several different theories of dependency. From a classical psychodynamic approach, dependency is seen as stemming from a fixation at the oral stage. In those people who develop dependency there is either frustration or overgratification of the infant's needs during the oral stage of psychosexual development. This results in the infant becoming fixated at this stage and developing conflicts regarding dependence and independence. If a fixation happens, the person will remain dependent on others for nurturance and support, and they will continue to exhibit behaviors in adulthood that reflect the oral stage of development such as preoccupation with activities of the mouth and reliance on food and eating as a means of coping with anxiety (Freud, 1905).

More contemporary models of dependency come from object relations and what Bornstein (1992) terms the "ethological models" which both evolved following the classical psychoanalytic theory. Both of these models deemphasize the importance of actual oral activities in determining the development of oral dependent traits and behaviors (Greensberg & Mitchell, 1983). Instead the overall quality of the infant-caretaker relationship is

emphasized as the primary determinant of dependent traits in adulthood (Ainsworth, 1969). In the object relations model the separation-individuation phase and the development of the self-concept are emphasized as critical developmental tasks that occur during infancy and early childhood. The infant-caretaker relationship is thought of as a prototype for later interpersonal relationships (Bornstein, 1992). The self and object representations that the child internalizes from infancy through their early childhood are hypothesized to play a central role in personality development and dynamics throughout the rest of their life (Bornstein, Galley, & Leone, 1986)

In the ethological approach, the innate biological underpinnings of the infant-mother bonding as determinant of the self-concept and subsequent interpersonal behavior is emphasized (Bowlby, 1969). The primary caretaker provides both the biological and psychological gratification to the infant, and then the caretaker becomes associated with pleasurable experiences. Thus the caretaker in effect becomes a secondary reinforcer (Bornstein, 1992). If the infant generalizes the beliefs and expectations regarding the caretaker to other potential caretakers, the person will display dependent behavior in those relationships. Ainsworth (1969) noted that

“a class of behaviors learned in the context of the infant’s dependency relationship with his mother, although first dependency relationship is a specific one, dependency is viewed as generalizing to subsequent interpersonal relationships” (p. 70).

Thus, dependent behaviors are exhibited because they either are rewarded, were rewarded in the past, or the dependent person perceives that they will be rewarded. The differences in childhood and adult dependency result from the variations in the degree to which passive,

dependent behavior was reinforced by the primary caretaker during the person's childhood (Bornstein, 1992).

If the psychoanalytic and attachment and learning models of dependency are compared it is apparent that in the psychoanalytic model that people will be conflicted regarding underlying dependency needs while in the Learning model a dependent person would increase dependent behavior because this behavior gets reinforced. In the psychoanalytic theory the infantile dependency needs are unconscious, and there is a struggle between these unconscious dependency needs and conscious prohibitions against expressing the needs (Bornstein, 1992). Bornstein (1992) explains that in the social learning theory this conflict comes from inconsistent socialization practices that have occurred during the person's childhood. Children are taught that they need to obey figures of authority and to depend on them for nurturance, protection, and guidance. When these behaviors get reinforced the child will learn to display dependent behavior (Bornstein, 1992).

Bornstein (1992) also explains that the most important similarity between psychoanalytic and the social learning models is the role of dependency and related cognitions in the development and expression of dependency behaviors. Bornstein (1992) explains that in the psychoanalytic model the mental representations of the parents and other significant figures are hypothesized to play a key role in determining the degree to which a person experiences strong dependency needs. In the social learning model the beliefs and expectations regarding rewards and punishments associated with expressing dependency are regarded as central determinants of the person's dependency-related behaviors. The mental representations in the psychoanalytic theory and the beliefs and expectations of the social

learning theory share things in common like they are cognitive structures, both involve construction of abstract categories representing conceptually and functionally similar stimuli and events, and both require the ability to apply past experiences to novel situations (Bornstein, 1992).

### *The Dependency Spectrum*

Bornstein et al. (2004) state that it isn't clear if people have a fundamental need to relate to others, but that it is clear that people have a range of strategies to attain a comfortable sense of closeness and dependence or separation and distance with others in their life. Bornstein and Languirand (2003) developed a model of dependency that places dependency related behaviors on a continuum, with Destructive Overdependence on one end and Dysfunctional Detachment on the other end, in their creation of the Relationship Profile Test. Destructive Overdependence includes individuals who are preoccupied with abandonment and who display a pattern of being overly accommodating and self-sacrificing. These are people who seem to be unable to make decisions for themselves and in the end alienate themselves from others by being insecure, needy, and clingy (Bornstein, 2005).

Bornstein (2005) states that detachment is when a person deliberately distances him/herself from other people and avoids intimacy and closeness. If detachment is severe there will be an aversion to all forms of social contact and the person will have a somewhat schizoid quality. Dysfunctionally Detached individuals often see others as being unpredictable, and they have a tendency to respond to conflict by completely shifting their attitude toward the other person and viewing them negatively. Overall this is a picture of a person who is isolated, has difficulty expressing feelings, and is overall dissatisfied with life.

In the middle of the spectrum lies Healthy Dependency. These people have self-confidence and self-directedness. They exhibit flexible, situation-appropriate help and support seeking behavior (Bornstein, 2005). They are outgoing and agreeable, secure and socially competent, and they report low levels of egocentricity and social anxiety. Their relationships are absent of problematic interpersonal behavior, and they are capable of being assertive without being overly intrusive and accommodating of others' wishes without disregarding their own needs. They are comfortable with closeness with others, and they lack anxiety about abandonment and rejection. Bornstein (2005) points out that a successful treatment in psychotherapy with a dependent patient would be to get the person to healthy dependency and not go too far to where the person has rigid independence or dysfunctional detachment.

Bornstein's (1992, 1993) four-component model, which consists of cognitive, behavioral, emotional, and motivational aspects, provides a theoretical basis to understand the Dyfunctional Detachment, Destructive Overdependent, and Healthy Dependent constructs. Haggerty, Blake, and Siefert (2010) state that all three of these dependency types reflect beliefs the person has about self and others, pervasive emotional responses to interpersonal encounters, affiliative motives, and a spectrum of behaviors that are used in order to attain the optimal level of interpersonal relatedness. Destructive Overdependent individuals cognitively have a perception of himself/herself as being weak and ineffectual. They have a fear that others will have a negative evaluation of them, and so they also have abandonment concerns. They are motivated to maintain close ties to caregivers and authority figures, and behaviorally they appear clingy, seeking reassurance, and come across as helpless. The Dysfunctionally Detached individual cognitively has a perception of others as



being hurtful or untrustworthy. The emotional component includes a fear of being hurt or overwhelmed. They are then motivated to maintain distance from others and maintain control. Behaviorally they appear rigidly autonomous. The Healthy Dependent individual cognitively has a perception of themselves as being competent and others as being trustworthy. They find security in intimacy and confidence in autonomy. They are motivated to maintain closeness in the context of autonomy and self-reliance. Behaviorally they appear autonomous coupled with situation-appropriate help seeking.

Overall it is suggested that Dysfunctional Detachment is the opposite of Destructive Overdependence (Haggerty, Blake & Siefert, 2010). It is more closely related to a schizoid personality disorder, and it is currently thought of as not being able to have circumstance-appropriate affiliative behaviors (Haggerty, Blake, & Siefert, 2010). However, Destructive Overdependence, Healthy Dependence, and Dysfunctional Detachment are all ways for an individual to gain the optimal level of interpersonal closeness with which they are most comfortable.

### *Dependency Research*

Most research to date has focused on dependent personality as a categorical construct (e.g. Dependent Personality Disorder) although there has been support for the continuum model of dependency; Destructive Overdependence, Dysfunctional Detachment, and Healthy Dependency (Bornstein, 2001). Finney (1961) found a significant correlation between maternal protectiveness and a child's dependency as well as a mother's tendency to reinforce dependent behavior and the child's dependency score. Ojha and Singh (1988) also found that parental overprotectiveness was associated with an increased dependency score in college-

aged children. Parker and Lipscombe (1980) sampled a group of adult medical patients and found that patient reports of their parents as being overprotective was also associated with increased dependency. Vaillant (1980) found similar results with memories of parents as harsh and demanding during childhood were associated with elevated levels of dependency. In addition studies of infant-parent interactions, parenting style, and parental perceptions in adult subjects suggest that overprotectiveness and authoritarianism may play a significant role in determining the level of dependency (Vaillant, 1980). These styles of parenting may reinforce dependent behavior and prevent the child from engaging in independent behavior since parents don't let the child engage in the trial and error learning that is involved when the child is developing their independence. In several studies, parental reinforcement of dependent behavior or punishment for the child's independent behavior predicted levels of dependency in later childhood and adolescence (Finney, 1961; Fu, Hinkle, & Hanna, 1986; McCord, McCord, & Thurber, 1962).

Dependency has also been studied in relation to gender and sex roles. There have been higher levels of dependency found in women over men on self report measures of dependency (Birtchnell & Kennard, 1983; Conley, 1980; Lao, 1980). This same finding happens when samples of school aged children are used (Chadha, 1983; Ederer, 1988; Gollightly, Nelson, & Johnson, 1970). However, when projective measures of dependency are used both men and women have been found to have similar levels of dependency (Bornstein, Leone, & Galley, 1988; Greenberg & Bornstein, 1989). Bornstein (1992) suggests that this is most likely due to the face validity of these two different types of measures. In self report measures men may be less willing than women to acknowledge their

dependent traits and feelings even if they are aware of them. In projective measures it is more difficult to disguise or distort their traits and feelings. Studies have also shown that there is little to no difference in levels of dependency in early childhood (Maccoby & Jacklin, 1974). However, as age increases the gender differences increase (Kagan & Moss, 1960). Bornstein (1992) suggests that this is due to sex role socialization. Boys are taught to not express dependent behavior and feelings while girls are encouraged to exhibit passive dependent behavior. However, when we look at the projective measures men and women have comparable underlying dependency needs, but the overt expression of these needs in the self report measures is due to the sex role socialization.

Bornstein and Bowen (1995) explain how the overprotective authoritarian parenting will be different with both girls and boys. In girls, parents will both work together to promote dependent behavior (Maccoby & Jacklin, 1974). In boys, there are interactive effects of this type of parenting with the traditional sex role socialization experiences. The overprotective authoritarian parents are more likely to encourage sex role types of behavior while also discouraging independent decision making and autonomous behavior (Gilbert, 1987; Mischel, 1970). The most immediate effects of overprotective authoritarian parenting is the construction of a particular mental representations of the self and other people, acquisition of particular kinds of beliefs regarding one's own self efficacy and regarding the power and potency of others (Birtchnell, 1988; Millon, 1987).

Early relationships with caregivers are important to the development of the self-concept. Children of overprotective authoritarian parents come to believe they can't function adequately without the guidance and protection of others, especially figures of authority

(Baumrind, 1973). Bornstein (1992) explains that cognitive structures that get formed in these early experiences within the family will later influence the motivations, behaviors, and affective responses of the person. If the person has the perception that they are powerless and in constant need of guidance and support then they will be motivated to seek guidance and support, protection, and nurturance from others. This then leads to a predictable pattern of behaviors. The person will also have fears of abandonment, performance anxiety, and fear of negative evaluators.

Overprotective and authoritarian parents send an implicit message to their children that they are vulnerable and weak (Bornstein, 2005). In addition illness has been shown to be related to the development of dependency. Early episodes of serious illnesses increase the likelihood that a child will develop dependent traits later on in their life. Bornstein (2005) states that this is because it contributes to the helpless self-concept and also elicits overprotective parenting. Also, physical and sexual abuse has been associated with dependency. This has been suggested that this is due to feelings of being powerless in response to the abuse (Hill, Gold, & Bornstein, 2000).

Dependency has also been studied in relation to psychopathology. There has been a significant positive relationship between levels of dependency and the level of depression in the individual in both clinical and nonclinical samples (Bornstein & Johnson, 1990; Robins, 1990; Hirschfeld, Klerman, Gough, Barrett, Korchin, & Chodoff, 1977; Klein, Harding, Taylor, & Dickstein, 1988). However, the magnitude of the relationship between dependency and depression is higher in men than it is in women, a finding that has been attributed to differences in gender role expectations (Blatt, D'Afflitti, & Quinlan, 1976; Klein, 1989;

O'Neil & Bornstein, 1991). O'Neil and Bornstein (1991) suggest that characteristics associated with dependency tend to predispose the individual to experience depressive symptoms. Akiskal, Hirschfield, and Yerevanian (1983) also suggest that dependency could be a product of depression. Abramson, Seligman, and Teasdale (1978) also proposed an explanation for this relationship, stating that dependency and depression may be products of the same underlying variable, which they term, learned helplessness. Blatt (2004) suggests that gender incongruence may be associated with increased risk for depression. Dependency in men might be seen as problematic to others which leads to implicit and explicit criticism as well as criticizing oneself and having the feeling that they are not really a man. If this theory is true, then women who are dependent would be less likely to exhibit depression since they would be displaying the character traits expected of a woman.

Individuals that rate high in dependency characteristics exhibit elevated rates of anxiety disorders and psychosomatic disorders (Reich, Noyes, & Troughton, 1987; Hayward & King, 1990). Bornstein (1992) suggested that dependency may act as a diathesis, and when it is coupled with interpersonal stress it places an individual at increase risk for Axis I pathology.

The behaviors that underlie dependency have also been subject to study. Jakubczak and Walters (1959) discovered that dependent subjects are more susceptible to peer influence than nondependent subjects. This effect is even more pronounced when the person is someone of high-status rather than a peer. Kagan and Mussen (1956) found that dependency scores on the Thematic Apperception Test were associated with increased yielding to the majority opinion. Agrawal and Rai (1988) found that dependent subjects were more

compliant as well. Overall dependency is associated with a general tendency to be influenced by the opinions of others, to yield to others in interpersonal transactions, and to comply with others. Bornstein (1992) suggests that when a dependent person is placed in the position of pleasing either an authority figure or a peer, they will please the authority figure. This is because the dependent person will be most likely to gain the guidance, support, and protection they seek from an authority figure.

Dependent males have also been shown to display significantly more help seeking behaviors than males who are not dependent (Bernardin & Jassor, 1957). Shilkret and Masling (1981) similarly found that dependent male subjects asked for help more frequently than nondependent males regardless of the gender of the experimenter. With female subjects the results differed slightly. Females who were dependent would ask for help more frequently than nondependent females only when the experimenter was female, but not when the experimenter was male. Masling, Johnson, and Saturansky (1974) found that under certain conditions people who are dependent are more accurate social perceivers than nondependent people. They found that males in the Peace Corps who were dependent were more accurate in predicting their roommates answers on questions about child-parent relationships, interpersonal relationships, values, and personality. Bornstein (1992) also points out that some research has supported the idea that dependency is associated with interpersonal sensitivity in both children and adults, but interpersonal sensitivity seems to be particularly stronger for adult males than it does for adult females. In addition, Hollender, Luborsky, and Harvey (1970) found that in undergraduate women, those who were dependent would express a greater desire than the nondependent women for physical contact with their

romantic partner. Similarly Sroufe, Fox, and Pancake (1983) found that dependent nursery school children sought physical contact with the teacher more frequently than the nondependent children did. In therapy dependent patients miss fewer therapy sessions, adhere more conscientiously than nondependent patients to regimens, and behave in ways they expect will please the therapist (Bornstein, 2005).

Bornstein (2005) states that dependency includes four components. The first is that dependent people are motivated by their need for support and approval from others (Bornstein, 2005). Second, cognitively dependent people have a perception of themselves as being powerless and ineffectual. The third component is that they tend to become anxious when they are required to function autonomously (Bornstein, 2005). The fourth part is that they tend to behave in a way that they believe will strengthen ties to potential caregivers. Nonetheless, dependent patients exhibit broader ranges of behaviors than the early psychoanalytic and learning theories suggested. In many situations, they are passive and compliant, trying to gain favor with others by presenting themselves as meek and weak. However, in other situations, for example, when a relationship is threatened, they become assertive and aggressive, and use whatever strategies they can to make sure they will not be abandoned (Bornstein, 1995; Bornstein, 2005).

Dependency has been associated with both positive and negative behaviors. Negative traits such as suggestibility and conformity, with a risk for certain psychological disorders like depression and tobacco addiction, have been associated with dependency. Several studies have documented increased physical illness, relationship conflict, and occupational difficulty (Bornstein, 2005). Positive traits, like the ability to infer accurately the attitudes

and beliefs of others and the desire to perform well in psychological experiments, have also been associated with dependency (Bornstein, 1992). While dependent people are often thought of as being passive and compliant, this isn't always the case. Juni (1981) found that dependent people ask for feedback on psychological tests more readily than nondependent people. Shilkrat and Masling (1981) found that dependent people ask for help when trying to solve difficult problems in the laboratory more often than nondependent people.

Dependency has been associated with sensitivity to interpersonal cues (Masling, Schiffner, & Shenfeld, 1980).

Dependent people have also been shown to present with adaptive help seeking behavior in medical settings (Bornstein & Kennedy, 1994). They are able to gain the maximum benefits from medical treatment partly because they have such conscientious patient-related behavior and will be compliant with medical regimens (Poldrugo & Fortti, 1988). Greenberg and Bornstein (1988) found that dependent people are much quicker at seeking medical attention than nondependent people are when their symptoms first appear. Dependent people have been found to be more trusting, straightforward, altruistic, compliant, modest, and tender minded (Lowe, Edmundson & Widiger, 2009). However, Costa and McCrae (1985) suggest that this level or degree of agreeableness found in dependent people could also be a pathological form. Healthy Dependency and Destructive Overdependence both involve low agency and a high level of agreeableness, which is consistent with terms used to describe dependent people like docile, servile, self-sacrificing, modest, compliant, clinging, obedient, gullible, submissive, self-effacing, and dependent (Pincus, 2002). Other studies have shown additional support for the relationship between agreeableness and



dependency (Samuel & Widiger, 2004; Sprock, 2002). Therefore dependent people are also characterized by their help seeking behaviors, but they are also assertive and active in situations when they perceive they are being abandoned. Bornstein (1992) states that there is one goal that underlies how a dependent person will behave in different situations and that is obtaining and maintaining nurturing and supportive relationships. The dependent person will yield to group pressure in most situations except when it will displease an authority figure (Masling et al., 1968; Bornstein et al., 1987). Bornstein (1992) states that the dependent person will choose the behavior that they believe will increase their chances of obtaining these nurturing relationships in the particular situation that they are in. Therefore, a dependent person will be passive when they think this will lead to this goal, and they will be active and assertive when they think this will lead to their goal.

We can then think of the passive behavior not as dependent individuals lacking assertiveness but as presenting themselves in a strategic way to make certain impressions on others and achieve their goals of obtaining nurturance and support. It has been found that these passive behaviors serve as social cues to elicit support and helping behaviors from others (Baker & Reitz; Berkowitz & Daniels, 1963). In psychotherapy, patients with dependent personality disorder have shown significantly higher rates of treatment compliance than patient in any others group (75% vs. 33%) (Poldrugo & Forti, 1988). This pattern may reflect the dependent patient's desire to be nurtured, protected, and cared for by an omnipotent figure of authority (Bornstein, Krukonis, Manning, Mastrosimone, & Rossner, 1993). These patients are more willing to take on the patient role and allow the figures of authority to guide and direct their behavior. However, Emery and Leshner (1982), explain that

when working with these patients there can be strong negative feelings in the therapist. They may make the therapist feel overwhelmed by the helplessness and neediness of the patient (Gilbert, 1987). The therapist may then engage in behaviors to try to distance themselves from the patient. These behaviors may be similar in a primary care setting where patients become familiar and develop a trust with their physician.

Bornstein (1992) states that the behavior of a dependent person can only be understood in the context of the particular situation that they are currently in. The core motivation will always be the same, and the behavior will change based on the person's perception of the situation and what will lead to the desired outcome of nurturance and support.

Sadikaj, Moskowitz, and Zuroff (2011) argue that the variations in early experiences with attachment figures underlie the individual differences in attachment dynamics. They also defined attachment anxiety as the degree to which an individual worries and is vigilant about being rejected, unloved, or uncared for by others. Attachment avoidance reflects the person's discomfort with intimacy, closeness, and interdependence. They suggested that each person's attachment style is related to a distinct pattern of affect regulating strategies. Attachment avoidance would be associated with the use of deactivating affect regulating strategies like suppression of the perception of threat-related cues, maintenance of emotional independence from others, and inhibition of proximity and support seeking toward others (Cassidy, Shaver, Mikulincer, & Lavy, 2009). This would manifest as reduced affective reactions to their partner's behavior as well as weaker and negative affective reactions to others' behaviors towards them. Those individuals who are avoidant will show blunted

positive and negative affective responses in association with the perception of others' behaving more or less agreeably. Behaviors that they perceive as cold and quarrelsome may act as a cue of threat to the relationship. These individuals may modulate both their positive and negative affects by preserving their emotional distance.

Personality traits have been talked about in terms of the Five Factor Model. These are the five broad domains of personality which are used to describe human personality. In this model there are five categories; openness, conscientiousness, extraversion, agreeableness, and neuroticism. Each of these five dimensions consists of a cluster of more specific traits. Pincus and Gurtman (1995) talk about what they term the submissive dependents which are described as being somewhat similar to the dysfunctional detachment personality style described by Bornstein et al. (2002). Submissive dependent individuals are more vulnerable to depression when there is a lost or disturbed relationship especially when it is with a nurturing attachment figure. These individuals also have low conscientiousness, low openness, and high agreeableness which are three dimensions of the Five Factor Personality Model. They see themselves as being incompetent and may consistently evoke dominant behaviors from others who continue to take control in the relationship. These responses will reinforce the person's poor self-concept (Brokaw & McLemore, 1991; Horowitz & Vitkus, 1986).

Blatt, D'Afflitti, and Quinlan (1976) examined the dependency items on the Depressive Experiences Questionnaire and found support for two separate types of dependency. Neediness is the primary maladaptive component found. It reflects the generalized undifferentiated dependence on others as well as feelings of helplessness and

fears of desertion and abandonment. The more adaptive component is connectedness. It represents the valuing of relationships and sensitivity to the effects of one's actions on others (Rude & Burnham, 1995). Neediness has been linked to submissive traits and behavior whereas connectedness has been associated with communion and feeling comfortable with closeness (Whiffen, Aube, Thompson, & Campbell, 2000).

Although connectedness is related to adaptive interpersonal functioning, connected individuals may also be prone to experience anxiety when they are concerned about the disruption of a relationship (Blatt et al., 1995; Pincus, 2002). However, neediness has also been found to be more strongly related to dysphoria than connectedness has (Blatt et al., 1995; Rude & Burnham, 1995; Whiffen et al., 2000). Zuroff, Moskowitz, and Koestner (1996) found that neediness is also positively related to Neuroticism and negatively related to Extraversion and Conscientiousness, which are three of the five factor personality model dimensions. Connectedness was related to Neuroticism, but to a lesser extent than neediness was. However, it was also positively related to Agreeableness and Conscientiousness.

Bacchiochi, Bagby, Cristi, and Watson (2003) found that neediness was positively related to anxiety, depression, and vulnerability facets of neuroticism, and it was negatively related to the assertiveness facet of extraversion. Connectedness was not significantly related to any of the Neuroticism, Extraversion, or Openness facets, but was related to Agreeableness. Bacchiochi et al. (2003) then suggested that the picture of the needy dependent individual is one where the person prefers to stay in the background and let others do the talking, lackadaisical, lazy, and lacking ambition. All of this would reflect their helplessness and dependence on others. Connected individuals on the other hand would

describe themselves as affectionate, friendly, and easily able to form attachment to others. They are receptive to their own inner feelings and emotions, concerned for others' welfare, and moved by others' needs. This all is related to the fact that they value relationships. These two constructs both share the fact that they are nervous, fearful, and prone to worry, but neediness is more closely related to depressive symptoms than connectedness is.

Blatt and Zohar (1990) also identified two different subscales in the DEQ dependency factor. The first one they labeled anaclitic dependence. This scale reflects feelings of helplessness, fears and apprehensions about separation and rejection, intense concerns about possible loss of gratification, and experiences of frustration. The second they called mature relatedness, and items that were included in this factor concerned the reaction to loss and loneliness to disruption of a relationship with a particular person. Blatt, Zohar, and Hart (1996) also identified two subscales of dependency on the dependency factor of the DEQ. They noted that these two different subscales seem to assess reactions to disruption of interpersonal relations at two different developmental levels. The first is a level of dependence in which there are intense and generalized fears and apprehensions about being alone and abandoned. The second is a level of relatedness in which there are feelings of loss associated with the disruption of significant relationship with a particular special person.

When Bornstein and Languirand's (2004) model of dependency has been specifically examined it has been shown that Dysfunctional Detachment may be the result of early parenting history that overemphasizes independence and self-sufficiency like that of authoritarian parents (Haggerty, Blake, & Siefert, 2010). These individuals also are more likely to have innate temperaments, which will serve to elicit detachment-promoting

reactions from parents and other authority figures (Coolidge Thede, & Jang, 2001). These individuals have a positive view of themselves as being self-reliant and a negative model of others, where they believe others as being incapable or unwilling to provide support and comfort (Haggerty, Blake, & Siefert, 2010). In order to cope, they keep their attachment to a minimum and exhibit an over reliance on their own competency, and they strive for independence (Haggerty, Blake, & Siefert, 2010). This is in contrast to the Destructive Overdependent person, which results from overprotection and authoritative parenting. They also have a more negative model of themselves and a positive model of others where they see them as being more competent than themselves (Haggerty, Blake, & Siefert, 2010). In order to cope they stay hypervigilant about real or imaginary abandonment (Haggerty, Blake, & Siefert, 2010). Detachment has been found to be related to increase risk of illness. For those who fall into the Dysfunctional Detachment group this risk seems to come from their difficulty in engaging in adaptive affiliative behaviors as well as difficulty in expressing their negative emotions. By doing this, the person must use a great deal of effort which will place a burden on the mind and body (Pennebaker, 1997). Both ends of the continuum (Destructive Overdependence and Dysfunctional Detachment) are thought to increase the risk of an individual having either physical or psychological disorder due to their affect dysregulation (Bornstein et al., 2002)

Destructive Overdependent individuals have been shown to overuse mental health services, have difficulty terminating psychotherapy, and also obtain significantly higher number of psychotropic medications and prescriptions than nondependent patients (O'Neil & Bornstein, 2001). Overdependence is also associated with an increased risk for illness and

disease (Bornstein, 1998). On the opposite end of the spectrum Dysfunctionally Detached individuals are slow in seeking treatment after symptoms appear, and they will terminate psychotherapy treatment prematurely. In psychotherapy they show only modest benefits relative to the nondetached patients (Knotr, 1993; Sperry, 1995). Detachment, like Destructive Overdependence, leads to an increased risk for mental and physical illness because their alexithymic tendencies prevent them from disclosing negative emotions (Pennebaker, 1990).

In healthy dependent people, there is a history of authoritative parenting, which instills in the child a sense of confidence and self-directedness (Cross & Madson, 1997; Lee & Robbins, 1995). These individuals receive constant messages from their parents and other authority figures that are present in their life that it is acceptable to ask for support when it is needed (Clark & Ladd, 2000; Lang-Takac & Osterwell, 1992). Therefore, these individuals learn that looking to others for support is not a sign of weakness or failure. It is only when the authoritarian parenting style is linked with encouragement of situation appropriate help seeking that the child is able to develop a Healthy Dependent personality (Kobayshi, 1989; Singelis, 1994). Healthy Dependency leads to opposite outcomes in terms of health from both the Dysfunctionally Detached and Destructive Overdependent individuals. The Healthy Dependent person's combination of autonomy and connectedness facilitates the disclosure of troubled feelings, which leads them to cope more effectively with interpersonal conflict. This allows for more adaptive medical help seeking when symptoms appear (Bornstein et al., 2002). Healthy Dependent individuals have the ability to evaluate external influences critically and resist these influences if they so desire. We get an overall picture of a person

who has an interdependent self-construal, need for approval, ease in verbalizing feelings, and satisfaction with life. They are secure and confident, and they feel connected to other people as well as have a desire to please others without being overly concerned regarding the possibility of relationship conflict or disruption compared to Destructive Overdependent and Dysfunctionally Detached individuals (Bornstein et al., 2002; Bornstein, 2001; Bornstein, 2002).

Healthy dependency is very similar to the idea of secure attachment, but the two constructs differ in terms of their underlying process (Bornstein, 2002). Secure attachment is rooted in the internal working model of the person's self and other interactions that lead to positive expectations regarding relationship outcomes (Main, Kaplan, & Cassidy, 1985). Healthy Dependency is different in that it is rooted in a set of motives and affective responses that enable the person to seek help from others without feelings of helplessness. They are able to control and regulate their affiliative urges through internal means which allows them to delay their short term gratification (Bornstein et al., 2002). In secure attachment styles there is greater behavioral consistency that is seen across different situations. However, with healthy dependency, behavior is different in different settings since they modify their behavior in response to situational cues and external demands (Bornstein et al., 2002) These two different constructs have been shown to be empirically as well as conceptually distinct (Klohn & John, 1998). Individuals identified as Healthy Dependent have been associated with a more favorable perception of their mental health and social functioning (Huprich, et al., 2010).



These different styles of relating to people have been found to have different prevalence rates in women and men. Women consistently score higher on Destructive Overdependence and Healthy Dependency (Bornstein, 1995; Bornstein, Geiselman, Gallagher, Ng, Hughes, & Languirand, 2004). Men tend to score higher on the Dysfunctional Detachment scale but not significantly so (Bornstein, 1995; Bornstein et al., 2004). This is somewhat consistent with the DSM-IV-TR assertions regarding the gender differences in detachment. In the DSM-IV-TR it is stated that women and men are diagnosed with avoidant personality disorders at equal rates, but schizoid personality disorder is diagnosed more often in males (APA, 2000). Bornstein et. al. (2004) did examine the scales in regards to whether they reflect stereotypical masculine or feminine behavior. They found that the items on the Destructive Overdependence Scale (DO) were mainly reflective of female stereotypical behavior and the items on the Dysfunctional Detachment Scale (DD) were mainly reflective of the male stereotypical behavior. This has implications for understanding the interpersonal and intrapersonal dynamics of these different individuals. Those who are classified as Destructive Overdependent have low levels of masculine behavior, so they are typically unambitious, unaggressive, unassertive, and unwilling to take risks. Those who are classified as Dysfunctionally Detached have low levels of feminine behavior, so they will be relatively unempathetic, unaffectionate, and insensitive to the needs of others (Bornstein et al., 2004). Those individuals who are classified as being Healthy Dependent, report high levels of both masculine and feminine stereotypical behaviors. Thus they have a complex array of traits that enable the individual to combine intimacy with autonomy and seek reassurance and support without feeling weak or helpless. There is a strong correlation between Healthy Dependency

and androgyny which reflects that these individuals can vary their self-presentation and social influence strategies across situation and setting, and ultimately show flexibility in their responses (Bornstein et al., 2004).

Greenberg and Bornstein (1989) found that dependency is related to increased levels of depression, alcoholism, obesity, and smoking. Greenberg and Bornstein (1989) found that higher levels of dependency were associated with length of stay for women on a psychiatric inpatient unit. In addition, female eating disorder patients have higher scores on performance-based measures of dependency, like the Rorschach, than psychiatric controls (Bornstein & Greenberg, 1991). Bornstein (2001) further supported this by finding positive associations between interpersonal dependency and eating disorder symptoms and diagnoses. Huprich, Stepp, Graham, and Johnson (2004) also found that dependency was related to problematic eating behaviors in undergraduate men and women. O'Neill and Bornstein (2001) found that dependent inpatients received more medical consultations and psychotropic medications. These individuals present with many concerns about their physical health. They may also have negative perceptions about their current health status as well as concerns about their social activities being interfered with (Huprich, Hsiao, Porcerelli, Bornstein, & Markova, 2010). In a primary care setting individuals who were identified as being destructively overdependent were found to have impairment in performing various tasks like working around the house or going to school (Huprich et Al., 2010). O'Neill and Bornstein (2006) looked at dependency without separating individuals into the three different groups, and they found that higher levels of dependency were associated with greater treatment satisfaction for medical inpatients. Bornstein (1995) also found that dependency and

interpersonal stress predicts the increase of physical illness rates, and social support can decrease the negative effects of interpersonal stress to further improve the dependent individual's health status. This is not an unexpected finding since social support decreases the negative effects of stress on most people.

Bornstein (2002) explained that the relationship of health concerns with dependency can be understood in a psychoanalytic framework. There are unmet or overgratified oral needs which lead to greater dependency in the individual. These needs can manifest as maladaptive health-related behaviors such as overeating and smoking. Both the groups of Destructive Overdependent people and Healthy Dependent people seek health care readily when physical needs arise. When the help they want isn't available, Destructive Overdependent people become more distressed and depressed. This is either manifested as increased passivity or helplessness. It could also be manifested as an anxious self-critical stance. The Destructive Overdependent person would then blame themselves for failing to secure the help and support that they desire and for being unworthy of nurturance and care (Bornstein, 2005). Because these individuals desire to seek support and care, they can be overly critical of their ability to care for themselves and believe that they are in need of a more powerful caregiver who will provide for them (Bornstein, 2005). If a physician knows that a patient is overdependent and has a negative health perception, the physician can plan to see the patient more regularly, help the patient to develop a greater sense of agency, and gradually increase the time between visits to help the individual develop autonomy (Huprich et al., 2010).

Dysfunctionally Detached individuals use social withdrawal to manage their anxiety and cope with their distress (Bornstein et. al., 2002). Huprich et al. (2010) found that these individuals may feel particularly unworthy and fear rejection or criticism, so even though they may appear to be aloof and uninterested in relationships with others, they may have a great deal of mental energy invested in their sense of inadequacy. Huprich et al. (2010) also found that those individuals classified as Dysfunctionally Detached like the Destructive Overdependent group had negative perceptions about their health status, concerns about their social activities being impeded, and overall physical and mental health. Dysfunctional Detachment was also associated with a lower quality of life since there were impairments in performing chores around their house or difficulty going to school. Overall both Destructive Overdependence and Dysfunctional Detachment are related to negative perceptions and beliefs about health. Quite the opposite was found in Healthy Dependent people. These individuals have a favorable perception of their mental health including role functioning, social functions, and mental health symptoms (Huprich et al., 2010). Since both Destructive Overdependent patients and Dysfunctionally Detached patients have such negative health perceptions this is an area that Huprich et al. (2010) suggests that providers learn to make interventions.

High levels of detachment are associated with negative health outcomes. De Ganna, Stack, Serbin, Ledingham, and Schwartzman (2006) found that women from a disadvantaged neighborhood who were psychologically detached and withdrawn as children reported health concerns and problems earlier than participants who were matched and nondetached. These women also engaged in more risky health behaviors like smoking. Marusic and Goodwin

(2006) found that male medical inpatients who engaged in self harm behaviors reported high levels of detachment as a means of coping with their stress. Lehrner, Kalchmayr, Serles, Olbrich, Patariaia, Aull et al. (1999) found that patients who reported high levels of dependency on others and social withdrawal were associated with less participation in activities of daily life. It was suggested that diseases like epilepsy may lead to functional impairments and are followed by negative attitudes about being with others. The disease will require that the person has interpersonal aid and assistance. The detached individual will be prone to self-criticism and depression for needing these supportive relationships when they prefer isolation and self-sufficiency. They may also become depressed when these supportive relationships are not available even though they prefer not to ask directly for help or assistance. These individuals often use social avoidance and withdrawal as a way to manage their anxiety and cope with distress (Bornstein, 2002; Bornstein & Huprich, 2006). Studies have shown that the individual who is detached may feel particularly unworthy and fear rejection or criticism. They may also appear to be aloof and uninterested in relatedness. In addition, there may be a great deal of mental energy that is invested in their sense of adequacy and appearing good enough to others (Huprich, Hsiao, Porcerelli, Bornstein, & Markova, 2010). In a primary care sample these individuals were shown to have impairment in performing various tasks like working around the house or going to school (Huprich, et al., 2010). It is important to understand the link between dependency and detachment and health especially with the current emphasis in the United States for health care to justify treatment and maximize treatment efficiency and effectiveness.

Bornstein (1995, 2003) found that interpersonal dependency significantly predicts health status and health service use. Both Destructive Overdependent patients and Dysfunctionally Detached patients are more likely to have mild short-term illnesses as well as more serious illnesses like heart disease and cancer. In addition they make more visits to their health care providers, have more pseudo emergencies, and more requests for between session contact (Emery & Lasher, 1982). They also tend to receive more psychotropic medications and non psychiatric medical consultations than those who are nondependent (O'Neil & Bornstein, 2001). Porcerelli, Bornstein, Markova, and Huprich (2009) used the Relationship Profile Test to look at health care utilization and outcomes in Destructive Overdependent patients, Dysfunctionally Detached patients, and Healthy Dependent primary care patients. The Destructively Overdependent patients were found to have a higher number of chronic illnesses, elevated blood pressure, higher numbers of chief complaints, higher numbers of physician diagnoses, and higher numbers of somatic symptoms. For those patients considered dysfunctionally detached they were found to have significantly high number of chronic illnesses, elevated blood pressure, body mass index, and somatic symptoms. Those considered healthy dependent significantly and negatively correlated with number of physician diagnoses. In terms of health care costs Destructive Overdependence was associated with higher total outpatient costs and average cost per visit. Dysfunctional detachment was also associated with higher total outpatient costs. Destructive Overdependence was also associated with greater ER utilization. Bornstein et al. (2009) also found that Destructive Overdependence is positively correlated with pathology dimensions of depression, panic, anxiety, and eating disorders. There were also similar correlations found

between Dysfunctional Detachment and pathology dimensions. In contrast Healthy Dependency had significant negative correlations with depression, panic, anxiety, and eating disorders. Healthy Dependency was also correlated with lower healthcare costs and healthcare utilization. This suggests that the patients who are considered dysfunctionally detached or destructively overdependent are patients who will take a great deal of physicians' time and attention. They will be the patients that are more difficult to treat. This may cause the physicians to feel frustrated and lead to them viewing the relationship between themselves and these patients as being a difficult one.

### **Summary of the Proposed Study**

Previous research has demonstrated that difficult doctor-patient relationships are associated with (nonspecific) pathological personality traits and psychiatric diagnoses, including depression, anxiety, eating disorders, and somatization. This study expands upon the knowledge of the relationship between personality pathology and difficult doctor-patient relationships by assessing patients' level of pathological dependency. Pathological dependency has been implicated as an important patient feature associated with difficult doctor-patient relationships in both the clinical (Groves, 1978) and empirical literature (Bornstein et al. , 2003). In addition this study expands upon the current knowledge of difficult doctor-patient relationships by including patient's and physician's ratings.

### **Rationale For Hypotheses**

Previous research has indicated that Axis I disorders have been found to be predictive of a difficult doctor-patient relationship (Hahn et al., 1996). In addition, Hahn et al. (1996) found that patients perceived as being difficult by their physician have more functional

impairment and lower satisfaction with their medical care when compared to patients who were rated as not being difficult by their physician. Destructive Overdependent patients and Dysfunctionally Detached patients have been found to also be related to more functional impairment and lower satisfaction with health care (Huprich et al., 2010). Patients who are either classified as Destructive Overdependent or Dysfunctionally Detached have been found to have more health related concerns (Huprich et al., 2010) Therefore it was suspected that depression and anxiety would remain as predictors of a difficult doctor-patient relationship as perceived by the physician, but that Destructive Overdependence and Dysfunctionally Detached personality factors would add significantly to the predictive accuracy. In addition since Healthy Dependency is related to an overall sense of wellness (Huprich et al., 2010), it was expected that Healthy Dependency would be negatively and significantly correlated with difficult doctor-patient relationships. Multiple physical illnesses have been shown to be associated with difficult doctor patient relationships (Hahn et al., 1996). It is suspected that those patients who have multiple physical complaints would be rated by their physician as being less healthy than patients with less physical complaints and will be more strongly correlated with higher difficulty scores. Dependency was also expected to be negatively and significantly correlated with difficult doctor-patient relationships. Also, physicians who are more interested in treating and working with mental illnesses tend to rate more encounters with their patients as being difficult (Hahn et al., 1996). As physicians continue to improve their knowledge and skill in working with patients, they will become better at working with these difficult patients. Therefore it was expected that the fewer years of practice the physician has, the more likely the patients were to rate their encounters as being difficult.



## Hypotheses

- 1) Physician's ratings of patient's difficulty as measured by the DDPRQ-10 would be positively and significantly correlated with
  - a. Overall Mood Score (as measured by the Patient Health Questionnaire-4) which would reach at least a medium effect size of .30.
  - b. Destructive Overdependence (as measured by the Relationship Profile Test) which would reach at least a medium effect size of .30.
  - c. Dysfunctionally Detached (as measured by the Relationship Profile Test) which would reach at least a medium effect size of .30.
  - d. Number of years of practice by the physician which would reach at least a medium effect size of .30.
  - e. The overall health score of the patient as rated by their physician, which would reach at least a medium effect size of .30.
- 2) Patient's ratings of being difficult by their primary care physician would be significantly negatively correlated with healthy dependency (as measured by the Relationship Profile Test)
- 3) The mean score of Destructive Overdependence (as measured by the RPT) would be significantly higher in female participants than in male participants.
- 4) The mean score of Dysfunctional Detachment (as measured by the RPT) would be significantly higher in male participants than in female participants.
- 5a) The overall mood score (as measured by the PHQ-4), Destructive Overdependence (as measured by the Relationship Profile Test), Dysfunctionally Detachment (as

measured by the Relationship Profile Test), the number of years the physician has been practicing medicine, and the overall health score of the patient as rated by the physician would be predictors of a difficult doctor patient relationship in a Standard multiple regression.

5b) Destructive Overdependence (as measured by the Relationship Profile Test) would account for the most variance when predicting difficult doctor patient relationships with The Overall Mood Score (as measured by the PHQ-4), Dysfunctional Detachment (as measured by the Relationship Profile Test), the overall health score of the patient as rated by the physician, and number of years the physician has been practicing medicine adding to the prediction.

6) Patient's ratings of perceived difficulty in working with their physician ( as measured by the PDRQ-9) would be significantly correlated with

- a. The Overall Mood Score (as measured by the PHQ-4) which would reach at least a medium effect size of .30.
- b. Destructive Overdependence ( as measured by the Relationship Profile Test) which would reach at least a medium effect size of .30.
- c. Dysfunctional Detachment ( as measured by the Relationship Profile Test) which would reach at least a medium effect size of .30.
- d. Number of years of practice by the physician which would reach at least a medium effect size of .30.
- e. The patients overall health score as rated by the physician which would reach at least a medium effect size of .30.

7) Patient's rating of perceived difficulty in working with their physician (as measured by the PDRQ-9) would be significantly and negatively correlated with Healthy Dependency ( as measured by the Relationship Profile Test)

8a) The Overall Mood Score (as measured by the PHQ-4), Destructive Overdependence ( as measured by the Relationship Profile Test), Dysfunctional Detachment (as measured by the Relationship Profile Test), the patient's overall health score as rated by the physician, and number of years the physician has been practicing medicine would all be predictors of patient perceived difficulty in working with their physician in a Standard Regression Analysis.

8b) Destructive Overdependence ( as measured by the Relationship Profile Test) would account for the most variance in a standard regression model when predicting patient perceived difficulty in working with their physician with The Overall Mood Score ( as measured by the PHQ-4), Dysfunctional Detachment ( as measured by the Relationship Profile Test), the patient's overall health score as rated by the physician and number of years the physician has been practicing medicine, will add significantly in predicting difficult doctor patient relationships.

9) The Difficult Doctor-Patient Relationship Questionnaire ratings by the physician would be significantly and negatively correlated with the Patient Doctor Relationship Questionnaire ratings provided by the patient.

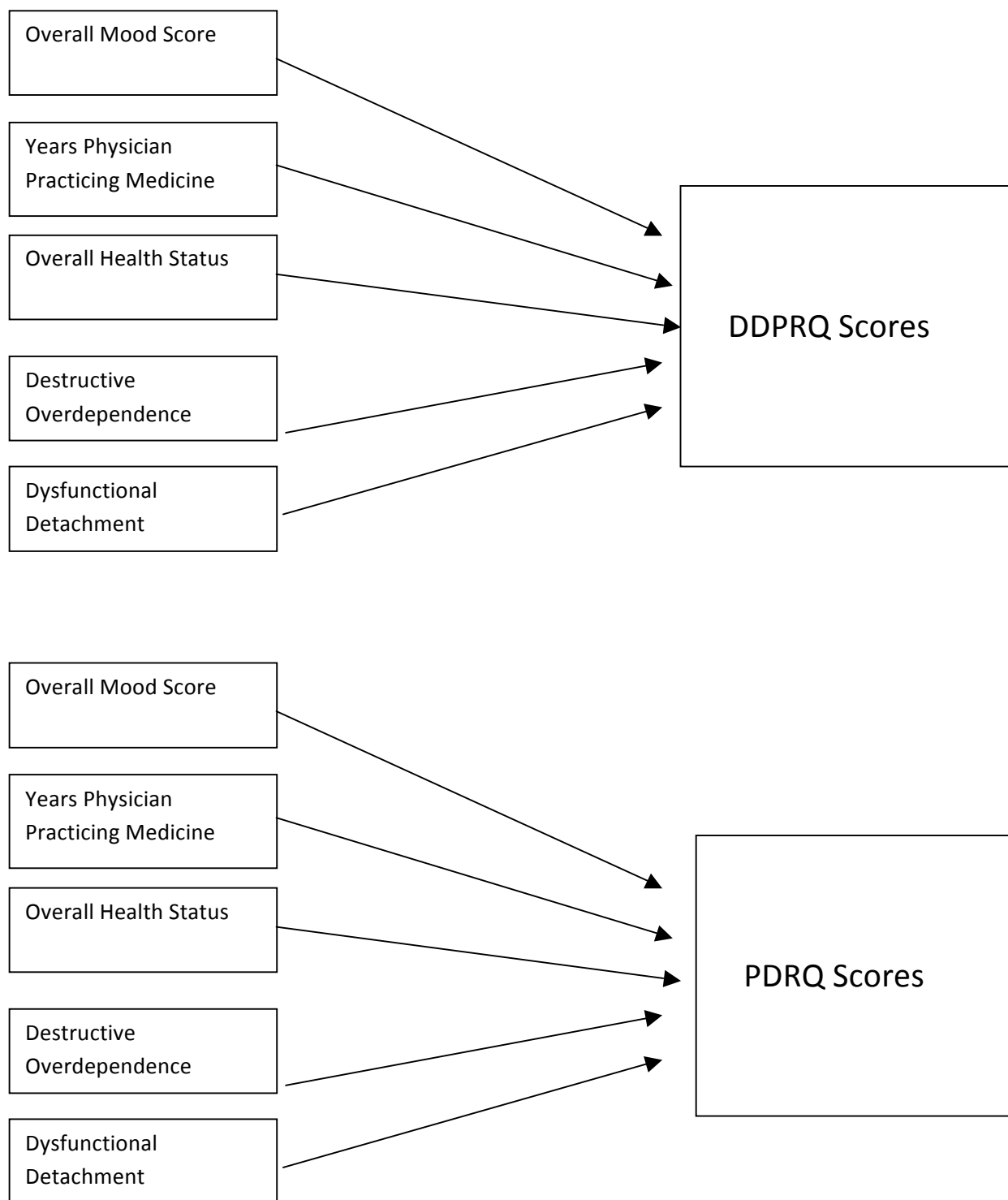


Figure 1. Schematic diagrams of hypothesized regression models

## **Chapter 3**

### **Method**

#### **Participants**

A total of 101 patients were recruited from the Wayne State University Family Medicine Center. Clinic patients were informed of the study by the primary researcher when they checked in at the front desk for their appointment. All participants were required to satisfy the following inclusionary criteria: a) the patient must have been at least 18 years old and b) the patient must not have had a guardian that comes with them to their visits to ensure the physician is rating their difficulty in working with the patient and not the difficulty in working with the guardian.

Physicians from the Wayne State University Family Medicine Center in Rochester Hills, Michigan were asked to participate in this study by the primary researcher. These physicians included first, second, and third year residents, and attending physicians. If a physician volunteered for participation and one of their patients agreed to take part in this study, they were informed by the primary researcher to fill out the DDPRQ-10 following the patient visit.

#### **Measures**

**Difficult Doctor-Patient Relationship Questionnaire-10 (DDPRQ-10; Hahn, Kroenke, Spitzer, Brody, Williams, Linzer, et. al., 1996)** The DDPRQ is a 10-item physician report questionnaire (see Appendix A) that was developed to a) identify patients experienced as difficult by their physician b) assess the degree of difficulty, and c) identify

the component parts of difficulty. It includes questions like “How much are you looking forward to this patient’s next visit after seeing this patient today?”, and “How enthusiastic do you feel about caring for this patient?” The physician rates their patient on a six point likert scale from “not at all” to “a great deal”. The initial scale was developed with thirty items, and Groves’s (1978) model of four different types of hateful patients was used as well as the principle that somatization is a critical component of physician experienced difficulty. There is an internal consistency reliability of .96 on the DDPRQ-10. The distribution of the scores is a skewed curve with a long tail at the end that contains about 20% of the population for all samples. Hahn et. al. (1994) found this pattern as well and that using the cutoff point of 90 out of a total possible score of 180 about 20% of the population was in the curve and identified as difficult. The DDPRQ-10 was created from the original measure using a forward regression on the original thirty items. It was found to have internal consistency reliability of .96 with the original instrument. Cronbach’s alpha was found to be .88. Each item is scored on a 6 point likert scale, so the scores could range from 10-60. It was found that 30 is the cut point for determining difficult patients with 205 of the population falling into this range. By using this cutpoint it was found that all patients that are rated at 30 or above will produce “physician dysphoria” (negative emotional response to the patient) and virtually all patients who are experienced as “demanding and irritating” by the physician will be classified as being difficult (Hahn et al., 1994). Hahn et. al. (1994) found internal reliability to be .88, but internal reliability alpha coefficient was found to be .89 in this study.

**The Patient Health Questionnaire (PHQ-4) (Kroenke, Spitzer, Williams, Lowe, 2009).** The PHQ-4, a 4-item patient self-report measure (“Not at all” to “Nearly everyday”)

(see Appendix B), was developed from the Patient Health Questionnaire (Spitzer, Kroenke, & Williams, 1999), and it can be entirely self-administered. It is used to assess patients for the presence of symptoms that correspond to DSM-IV disorders in primary care settings. There are two questions to assess Major Depressive Disorder and two questions to assess Generalized Anxiety Disorder. Each disorder can be scored using a categorical algorithm to assess the presence of the disorder or the total score can be combined into an overall mood score. Spitzer, Kroenke, and Williams (1999) compared the results from the PHQ with the results from an interview with a PhD clinical psychologist who conducted a phone interview with all subjects. The criterion validity for the major depression portion of the test has been found to be good with sensitivity equaling 73% and specificity equaling 98%. The overall accuracy was found to be 93%. The internal reliability has been found to be between .86 and .89, and test retest reliability after a 48-hour period has been found to be .84. The correlation between the PHQ and the PRIME-MD interview was found to be .54 (Spitzer, Kroenke, & Williams, 1999). Participants in Spitzer, Kroenke and Williams (1999) reported to have found the questions comfortable to answer and judged the information to be useful to their clinician. Four items from the PHQ were taken to create the PHQ-4. Confirmatory factor analyses of the PHQ-4 showed very good fit indices for a two-factor solution (RMSEA .027; 90% CI .023-.032). Construct validity of the PHQ-4 was supported by intercorrelations with other self-report measures and with demographic risk factors for depression and anxiety. Scores of 3 corresponded to percentile ranks of 93% on the Major Depression items and 95% on the Generalized Anxiety items, and scores of 5 corresponded to percentile ranks of 99% on the Major Depression items and 99% on the Generalized

Anxiety items. On the PHQ-4 the participant rates how often a symptom has bothered them for the past two weeks on four items that come from the Major Depression Scale and the Generalized Anxiety Disorder Scale on the PHQ. Scores range from 0 (“not at all”) to 3 (“nearly everyday”), and the total score can range from 0 to 12. Internal reliability alpha coefficient was found to be .71 for the two depression questions and .85 for the two anxiety questions in the present study.

**Relationship Profile Test (RPT; Bornstein and Languirand, 2003)** (see Appendix C). The RPT is a thirty item self report measure of dependency. It is made up of three subscales; Destructive Overdependence (DO), Dysfunctional Detachment (DD), and Health Dependency (HD). The DO scale is designed to identify those people who are withdrawn, socially inhibited, and have poor social skills. These people are preoccupied with abandonment and display a pattern of being overly accommodating and self-sacrificing. The DO scores have been found to be associated with insecure attachment, lack of self confidence, and an inability to regulate affect through internal means (Bornstein et al., 2002). The DD scale identifies those people who are shy, insecure, unassertive, and socially incompetent. They are alienated from others and relatively egocentric. They have low levels of agreeableness and high levels of dominance, vindictiveness, and coldness. The over dependent people cope with their feelings of isolation by trying to draw people close to them by attempting to please them. The detached individuals cope with their feelings of isolation by becoming aloof and unapproachable. The HD scale identifies those people who are outgoing and agreeable, secure and socially competent, and report low levels of egocentricity and social anxiety. Their relationships are absent of problematic interpersonal



behavior. They are capable of being assertive without being overly intrusive and accommodating of others' wishes without disregarding their own needs. They are comfortable with closeness with others, and they lack anxiety of abandonment and rejection. They are able to verbalize their feelings openly.

The three year test/retest reliability for the both DO and DD scales was found to be .52 and for HD it was .27 (Bornstein & Huprich, 2006). Scale reliability remained stable over both 85 and 158 weeks. At 158 weeks reliabilities were .60 for women and, .58 for men for the DO scale. They were .56 for women and .49 for men for the DD scale. The internal reliabilities for the scales are, .75 for HD, .68 for DD, and .83 for DO. HD is negatively correlated with DO (-.32) and DD (-.46) DD is negatively correlated with HD (-.37) and not correlated with DO (.00). DO is negatively correlated with HD (-.34) and only slightly (not statistically significant) correlated with DD (.10).

Bornstein and Huprich (2006) compared the subscales of RPT with three different previously validated measures to obtain convergent and divergent validity; the Bell Object Relations and Reality Testing Inventory (BORRTI), The Inventory of Interpersonal Problems (IIP-64), and the NEO Personality Inventory-Revised (NEO PI-R). If the DO subscale is in fact measuring what it is intended to, then high scores on the DO scale should be associated with high neuroticism scores and low scores on Extraversion, Openness and Conscientiousness on the NEO-PI-R. Also high DO scores should be associated with high scores on Alienation, Insecure Attachment, and Social Incompetence on the BORRTI. Along with that high DO scores should be associated with high scores on Social Inhibition, Non-Assertive, Overly-Accommodating, Self-Sacrificing, and Intrusive/Needy scales on the IIP-64.

When comparing the DO scores with the NEO-PI-R scales, they found that DO scores were significantly and positively correlated with Neuroticism, and they were significantly and negatively correlated with Extraversion and Conscientiousness. On the BORRTI the DO scores were associated with high Alienation, Insecure Attachment, and Social Incompetence. On the IIP-64 DO scores were associated with high scores on Social Inhibition, Non-Assertive, Overly Accommodating, Self-Sacrificing, and Intrusive/Needy.

If the DD scale is measuring what it is intended to then it should be associated with low Extraversion, Openness, and Agreeableness scores as well as high Neuroticism scores on the NEO-PI-R. On the BORRTI, high DD scores should be associated with high scores on all the four subscales; Alienation, Insecure Attachment, Egocentricity, and Social Incompetence. On the IIP-64 high DD scores should be associated with high score on the Dominant/Controlling, Vindictive/Self-Centered, Cold/Distant, Social Inhibition, and Non-Assertive scales. Bornstein and Huprich (2006) found that as expected DD scores were associated with low NEO-PI-R scores on Extraversion and Agreeableness as well as associated with high scores on the Neuroticism scale. On the BORRTI high DD scores were associated with all four subscales as expected. On the IIP-64 high DD scores were associated with high scores on Dominant/Controlling, Vindictive/Self-Centered, Cold/Distant, Social Inhibition, and Non-Assertive scales.

If the HD scale on the RPT is measuring what it is intended to then high scores should be associated with high scores on Agreeableness and low Neuroticism scores on the NEO-PI-R. They should also be associated with low scores on all four of the BORRTI subscales. In addition, high HD scores should be associated with low scores on all eight

subscales on the IIP-64. Consistent with what was expected high HD scores were associated with high Agreeableness and low Neuroticism scores on the NEO-PI-R. HD scores were associated with low scores on all four BORRTI subscales. They were also associated with low scores on all eight IIP-64 subscales. Internal reliability alpha coefficients in this study were found to be .82 for Destructive Overdependence subscale, .79 for the Dysfunctional Detachment subscale, and .816 for the healthy dependency subscale.

**Patient- Doctor Relationship Questionnaire (PDRQ-9; Van der Feltz-Cornelis, Van Oppen, Van Marwijk, De Beurs, & Van Dyck, 2002).** (see appendix D) The PDRQ-9 was developed to be a time efficient measure that could be used in a primary care environment. The questionnaire was designed to assess how the patient regards their primary care physician as an effective and helpful health professional. The PDRQ-9 consists of nine items scored on a 5-point likert scale. The Helping Alliance Questionnaire (HAQ; Alexander & Luborsky, 1984) which was designed to assess the patient's experience of the treatment or a relationship with a therapist as being helpful or potentially helpful, was used to guide the creation of the PDRQ-9. The nine items on the questionnaire have a Cronbach's alpha of .94. Test-retest reliability was also found to be .61 after 2 months. In order to assess validity they compared scores on the measure from patients receiving care in a primary care clinic with scores from patients receiving care in an epilepsy clinic. The rationale for this was that patients who are assessed in a specialist clinic for difficult to diagnose or treat refractive epilepsy or for medically unexplained symptoms mimicking epilepsy, might have a more negative view of their PCP. The researchers admit these are speculative reasons. However

the epilepsy group did provide lower ratings which give support for the discriminatory power. Further validity and reliability studies need to be conducted.

**Number of Years the Physician has been practicing medicine.** The physicians in the study are located at a primary care residency-training clinic. They include first year, second year, and third year residents along with attending physicians. When a physician signed consent for participation in the study, they were asked the year of residency of the number of years they had been practicing including their time spent in residency.

**Overall Patient Health Score.** (See Appendix A) The physicians were asked to rate the patient's overall health following their visit with the patient. A visual analog scale from 0 to 100 with 0 being extremely unhealthy and 100 being extremely healthy was used.

### **Procedure**

Participants were recruited from the Wayne State Family Medicine Center. The patient needed to be at least 18 years old to be asked to participate. Both males and females participated in this study.

When patients came in for a visit with their physician they were informed of the study by the primary researcher. The researcher told the eligible patients that there was a study being conducted to examine the relationship between patient health and relationships. They were also informed that the questionnaire would take about fifteen minutes of their time, and that they could complete it either while waiting to see their physician or following their visit. They were also told that participants would receive a 5-dollar gift card for their time upon completion of the questionnaires. If the patient wished to participate in the study, the

researcher handed the patient an information sheet and the survey. Completion of the survey was implied consent.

#### Primary Care Physician (Staff and Residents)

Physicians from the Wayne State Family Medicine Center in Rochester Hills, Michigan were asked to participate in this study by the primary researcher. These physicians included first year residents, second year residents, third year residents, and attending physicians. If physicians volunteered for participation when one of their patients agreed to take part in this study, they were informed by the researcher that they need to fill out the DDPRQ-10 as well as mark the patient's overall rating of health following the patient visit. Once they completed the questionnaire the researcher collected all surveys, put codes to identify the physician and patient, and then placed them in a locked file cabinet where only the researcher had access. The identifying information was kept separate from the surveys, and once data was entered all identifying information was shredded.

There was minimal risk to participants anticipated. However, having to answer questions about and think about their psychological state could have been distressing to some individuals. For this reason participants were provided with the researcher's contact information should they have felt the need to discuss their feelings following their participation. The study was approved by both the University of Detroit Mercy IRB and Wayne State University IRB.

#### **Statistical Analysis**

A total of 130 patients were approached to be in this study, and a total of 101 patients completed the survey with a 78% participation rate. There were a total of 18 resident and

attending physicians who completed surveys as a part of this study as well. There were 22.2% of the physicians that were first year residents (4 participants), 22.2% that were second year residents ( 4 participants), 33.3% that were third year residents (6 participants), and 22.2% that were attending physicians (4 participants). The effect size was set for .5 and power at .8. The probability level was set at .05, but it is important to note that this could lead to a Type I error. In past research studies have been able to set the effect size at a .5 level and achieve statistical significance using variables like anxiety, depression, and different characteristics of physicians (Hinchey & Jackson, 2011; Hahn et. al., 1994; Hahn et. al., 1996).

First a Pearson's Correlation matrix was constructed in order to test the first hypothesis that the DDPRQ-10 would be positively and significantly correlated with the overall mood score, Depression, Anxiety, Destructive Overdependence, Dysfunctional Detachment, the patient's overall rating of health as rated by the physician, and the number of years the physician has been practicing medicine. The Pearson's Correlation matrix was also used to test the second hypothesis that the DDPRQ-10 ratings would be negatively and significantly correlated with Healthy Dependency.

To test for differences as a function of gender, the mean scores on the Destructive Overdependence, Dysfunctional Detachment, and Healthy Dependency were compared between the female and male participants using an 3 one-way ANOVAs.

Next, a Standard multiple regression analysis was run to test the fifth hypothesis that Depression, Anxiety, Destructive Overdependence, Dysfunctional Detachment, the patient's overall score of health as rated by the physician, and the number of years the physician has

been practicing medicine would contribute to the prediction of DDPHQ-10 scores. If gender was found to be different between males and females on the measures of destructive overdependence and dysfunctional detachment on the previous analysis, then gender would have also been entered in this equation as an independent variable. The overall  $R^2$  would allow for an understanding of how much variance the independent variables together account for. In addition the analysis would provide semi partial correlation coefficients, which show the amount of variance accounted for by each of the independent variables alone. Since it has been shown that anxiety and depression are significant predictors of a difficult doctor-patient relationship when using the DDPHQ-10, this analysis allows for a better understanding of how the other five variables contribute to the prediction of a difficult doctor-patient relationship.

Following that, a second standard multiple regression analysis was planned to determine how Depression, Anxiety, Destructive Overdependence, Dysfunctional Detachment, the patient's overall score of health as rated by the physician, and the number of years the physician has been practicing medicine predict a difficult doctor patient relationship as rated by the patient on the PDRQ-9.

A Pearson's correlation matrix was constructed to test the sixth hypothesis that Overall mood score, Depression, Anxiety, Destructive Overdependence, Dysfunctional Detachment, the overall score of the patient's health and number of years the physician has been practicing medicine are significantly correlated with patient ratings of a difficult doctor-patient relationship. The matrix was also used to test for the seventh hypothesis that patient's

rating of perceived difficulty in working with their physician would be significantly and negatively correlated with Healthy Dependency.

After the matrix, a standard regression analysis was planned to test the eighth hypothesis that Depression, Anxiety, Destructive Overdependence, Dysfunctional Detachment, the patient's overall score of health and number of years the physician has been practicing medicine are predictors of a difficult doctor-patient relationship as perceived by the patient. If gender was found to be significantly different between males and females on the measures of Destructive Overdependence and Dysfunctional Detachment, then gender would have been included as another variable in the analysis. All variables were entered simultaneously. This allowed for an understanding of how much variance the variables together account for in predicting a difficult doctor-patient relationship when rated by the patients as well as how much variance each of the individual variables accounts for when predicting a difficult doctor-patient relationship.



## Chapter 4

### Results

#### Sample Characteristics

The mean age of patients was 40 years ( $SD = 15$ , skewness = .48, kurtosis = -.57) ranging from 19 to 76. A total of 71 (70%) of the patients were female (skewness = -.90, kurtosis = -1.21). There were 64 (63%) Caucasians, 29 (29%) African Americans and several others ethnicities patients participated in this study (skewness = 2.58, kurtosis = 6.72). The patients who participated had a range of education. Five (5%) had less than a high school degree; 36 (36%) with a high school degree, 31 (31%) with some college experience, and 29 (29%) with at least a college degree (skewness = -.69, kurtosis = -1.08). Forty-six of the patients were single (46%), there were 40 married (40%), 11 (11%) separated or divorced, and 4 (4%) described their marital status as other (skewness = .89, kurtosis = .54). Thirty-seven of the patients make less than \$20,000 (37%), 30 (30%) make in-between \$20 and \$39,999, 16 (16%) make in-between \$40 and \$59,999, 6 (6%) make in-between \$60 and 79,999, 9 (9%) make in-between \$80 and 99,999, and 3 (3%) make \$100,000 or more (skewness = 1.05, kurtosis = .20). There were a total of 31 (31%) who reported having a full-time job, 24 (24%) who reported having a part-time job, 27 (27%) reported being unemployed, and 19 (19%) reported their current job situation as other (skewness = .15, kurtosis = -1.33) ( see Table 1). Data was screened by two researchers and no errors were found.

Table 1

*Demographic Information for patients used in the present study*

Variable	Frequency	Percent
Gender		
Female	71	70.3
Male	30	29.7
Race		
White	64	63.4
African-American	29	92.1
Latino	1	1
Middle-Eastern	1	1
Asian	4	4
Other	2	2
Education		
Less than high school	5	5
High School	36	35.6
Some College	31	30.7
College Degree	29	28.7
Marital Status		
Married	40	39.6
Single	46	45.5
Separated/Divorced	11	10.9
Other	4	4
Income		
0-19,999	37	36.6
20- 39,999	30	29.7
40-59,999	16	15.8
60-79,999	6	5.9
80-99,999	9	8.9
100,000 +	3	3
Job		
Full-time	31	30.7
Part-time	24	23.8
Unemployed	27	26.7
Other	19	18.8

Following that, descriptive statistics of the independent and dependent variables used in the study were obtained and can be seen in Table 2.

Table 2

Descriptive Statistics of all Variables

	Mean	Standard Deviation	Skewness	Kurtosis
DDPRQ Scores	20.00	8.85	1.61	3.76
PDRQ Scores	40.70	6.11	-1.44	1.02
DO	24.60	7.71	.80	1.24
DD	31.40	7.43	.07	.32
HD	34.20	7.29	-.15	-.12
Depression	1.74	1.96	1.22	1.90
Anxiety	2.05	2.15	1.04	.69
PHQ Total	3.52	3.42	.75	-.52
Overall Health	64.10	24.10	-.37	-.71
Years of Practice	2.82	1.16	.40	-.29

First the hypothesis that DDPRQ scores would be significantly and positively correlated with the patients' overall mood scores, Destructive Overdependence, Dysfunctional Detachment, Number of Years of Practice by the physician , and the overall health scores of the patients as rated by their physician was tested. Correlations can be found in Table 3. This hypothesis was only partially supported. The DDPRQ scores were not significantly correlated with the patient's overall mood score, Destructive Overdependence, or years of practice. It was significantly and positively correlated with Dysfunctional

Detachment ( $r = .27$ ) and the patient's overall health score as rated by the physicians ( $r = .42$ ). The overall mood score was then broken down into two separate scores and the correlations between the overall depression score and the overall anxiety score and the DDPRQ scores were calculated. The overall anxiety score was not significantly correlated with the overall DDPRQ score ( $r = .02$ ). However, the overall depression score was significantly and positively correlated with the DDPRQ scores ( $r = .23$ ).

Following this, the next hypothesis that the DDPRQ scores would be significantly and negatively correlated with healthy dependency was tested. This hypothesis was not supported ( $r = -.01$   $p > .05$ ) (see Table 3)

Table 3

*Correlations between DDPRQ and PDRQ and the Independent Variables*

	DDPRQ	PDRQ
DO	-.08	.03
DD	.26***	-.01
HD	-.01	.04
Depression	.23**	-.09
Anxiety	.02	-.02
PHQ Total	.142	.01
Years of practice	-.06	.21**
Overall Health	-.42***	.05

*Note:* \*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$

The third hypothesis that the mean score on Destructive Overdependence would be significantly higher in female patients than male patients was tested using an one-way ANOVA (see Table 4). Males scored a mean of 23.4 (SD = 6.64) and females scored a mean of 25.18 (SD = 8.10). While females were slightly higher, they were not significantly so  $F(1, 101) = .281, p > .05$ .

The fourth hypothesis that the mean score of Dysfunctional Detachment would be higher in males with a small effect size was also tested using an one-way ANOVA (see Table 4). This was not supported. There was not a significant difference between the two mean scores,  $F(1, 101) = .92, p > .05$ , females had a slightly higher mean with 31.89 (SD = 7.39) when compared with the male patients with a mean score of 30.33 (SD = 7.53).

Table 4

ANOVA examining Destructive Overdependence scores and Dysfunctional Detachment scores according to gender

	Females (n = 71)	Males (n = 30)	F	Partial Eta Squared
Destructive Overdependence	25.18 (6.64)	23.37 (8.10)	1.173	.002
Dysfunctional Detachment	31.89 (7.40)	30.33 (7.43)	.921	-.001

The df = 1,100, Standard deviations listed in parentheses. \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

Following this a standard multiple regression analysis was used to test the fifth hypothesis that the overall mood score, Destructive Overdependence, Dysfunctional Detachment, number of years the physician has been practicing medicine, and the patient's overall health score as rated by the physician will be predictors of the DPPRQ-10 scores and 5b that Destructive Overdependence would account for the most variance in the equation with the rest of the predictors adding to it (see Table 5 and Appendix E). Given that the overall mood score was not significantly correlated with DDPRQ scores, the two constructs of depression and anxiety were put separately into the equation. The multiple regression model with all seven variables was statistically significant ( $R^2 = .32$ ,  $F(3,97) = 6.31$ ,  $p < .001$ ). The patient's overall health as rated by the physicians was the strongest predictor of the DDPRQ scores,  $t(101) = -4.32$ ,  $p < .001$ , followed by Destructive Overdependence,  $t(101) = -3.123$ ,  $p < .01$ , Depression,  $t(101) = 2.529$ ,  $p < .05$ , and then Dysfunctional Detachment,  $t(101) = 2.404$ ,  $p < .05$ . Upon examination of the semi-partial correlation coefficients, the patient's overall health status uniquely accounts for 43.80% of the variance in  $R^2$  of .32. Destructive Overdependence uniquely accounts for 21.88% of the variance. Depression uniquely accounts for 15.63% of the variance, and Dysfunctional Detachment uniquely accounts for 12.50% of the variance. This leaves 6.19% that is accounted for by the variables together.

Table 5

*Standard Regression model examining the predictors of DDPRQ scores (N=101)*

Predictor	B	SE	$\beta$	<i>t</i>	sr <sup>2</sup>	sign.
Years of Practice	.142	.687	.019	.207		.837
Destructive Overdependence	-.372	.119	-.324	-3.123	.07	.002**
Dysfunctional Detachment	.293	.122	.246	2.404	.04	.018*
Healthy Dependency	-.001	.111	-.001	-.013		.990
Depression	1.310	.518	.290	2.529	.05	.013*
Anxiety	-.404	.446	-.098	-.906		.367
Patient Overall Health	-.147	.034	-.399	-4.139	.14	.00***

*Df= (1,93) F= 6.313,  $p < .001$  R= .568 R<sup>2</sup>= .322 \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$*

Next the sixth hypothesis that patient's rating of perceived difficulty in working with their physician would be significantly and positively correlated with the patient's overall mood, destructive overdependence, dysfunctional detachment, number of years of practice by the physician, and the patient's overall health score as rated by their physician was tested. The only variable that emerged as being significant was the number of years of years of practice by the physician ( $r = .21, p < .01$ ) (See Table 3 above).

The seventh hypothesis that the patient's ratings of perceived difficulty in working with their physicians would be significantly and negatively correlated with healthy dependency was tested, and it was not supported ( $r = .04, p > .05$ ) as seen in Table 3 above.

The eighth hypothesis that the patient's overall mood score, destructive overdependence, dysfunctional detachment, the patient's overall health score, and the

number of years of practice by the physician would all be predictors of patient perceived difficulty in working with their physician, and hypothesis 8b that destructive overdependence would account for the most variance in the model was then tested (see Appendix F and Table 6). The overall model using all seven predictors was not significant ( $R^2 = .060$ ,  $F(3,97) = .846$ ,  $p > .05$ ). Despite the model not being significant the only variable that emerged as being significant in this equation was the number of years of practice the physician has ( $t(101) = 2.08$ ,  $p < .05$ )



Table 6

*Standard Regression model examining the predictors of PDRQ scores (N=101)*

Predictor	B	SE	$\beta$	<i>t</i>	sign.
Years of Practice	1.162	.558	.221	2.081	.040*
Destructive Overdependence	.057	.097	.072	.593	.555
Dysfunctional Detachment	-.021	.099	-.025	-.209	.835
Healthy Dependency	.010	.090	-.001	-.013	.990
Depression	1.310	.518	.012	.109	.914
Anxiety	.217	.362	.076	.599	.550
Patient Overall Health	-.003	.028	-.011	-.103	.918

*Df= (1,93) F= .85,  $p < .05$ ,  $R = .25$ ,  $R^2 = .06$*

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

Next the ninth hypothesis that the DDPRQ ratings by the physician and the PDRQ ratings by the patients would be significantly and negatively correlated was tested. This hypothesis was supported with the correlation being negative and significant ( $r = -.27$ ).

#### Supplementary Analysis

Next an analysis was done to see the correlations between the patients' age and Destructive Overdependence, Dysfunctional Detachment, Healthy Dependency, Anxiety, the patients' ratings of difficulty with their physician, the physicians' ratings of difficulty with their patients, and the patients' overall health status as rated by the physicians as seen in Table 7. The only two variables that emerged as being significant were the DDPRQ ( $r = .27$ ,  $p < .001$ ) and the patient's overall health status as rated by the physician ( $r = -.26$ ,  $p < .001$ ).

Table 7

*Correlations between Age and both Dependent and Independent Variables used in this Study*

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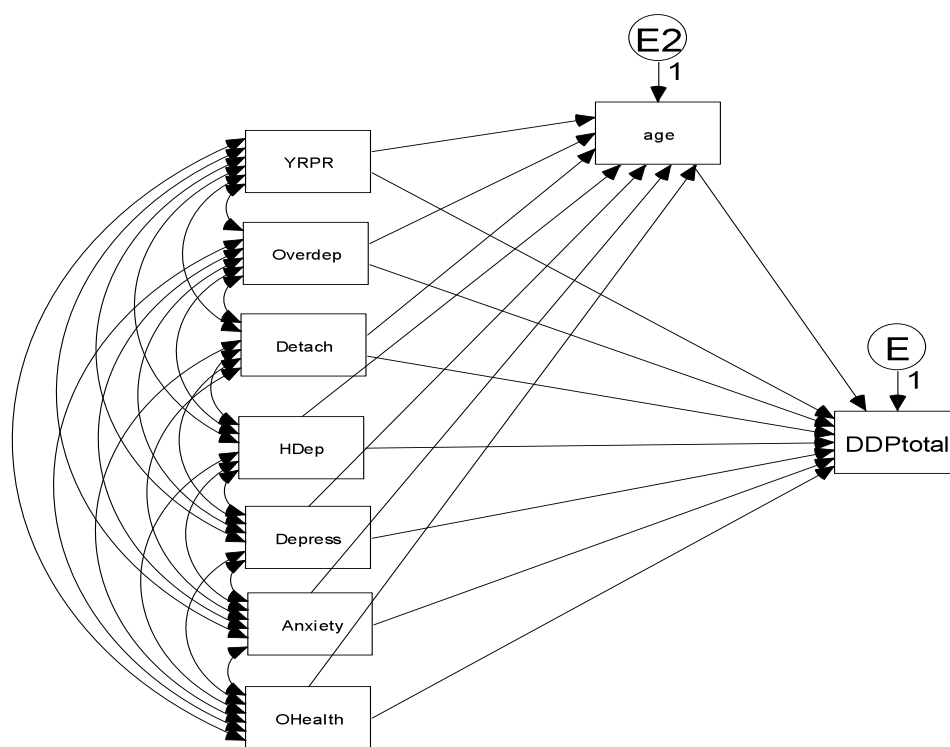
	Age
Destructive Overdependence	-.06
Dysfunctional Detachment	.01
Healthy Dependency	.02
Depression	-.07
Anxiety	-.13
PDRQ Total	-.08
DDPRQ Total	.27 ***
Patient Overall Health	-.26***
Years of Practice	.15

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\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

Given that age did correlate with one predictor (the patient's overall health) and the physician's ratings of difficulty, the researcher decided to create a path model to examine the role age played in predicting the difficult doctor patient relationships. This model was completed using Analysis of Moment Structures (AMOS). Age appears to be a partial mediator through its relationship between the patient's overall health ( $B = -.22$ ,  $\beta = -3.51$ ,  $p < .001$ ), the number of years of practice the physician has ( $B = 3.06$ ,  $\beta = 2.40$ ,  $p < .05$ ), and the ratings of difficulty provided by the physician ( $B = -.12$ ,  $\beta = -3.65$ ,  $p < .001$ ). While age does appear to account for some of the variance that is explained by the overall health score and the number of years of practice by the physician in predicting difficulty ratings made by the physician, it does not account for all of the variance.

Figure 2



## **Discussion**

The first hypothesis was that the physician's ratings of perceived difficulty would be significantly and positively correlated with the patient's overall mood score, Destructive Overdependence, Dysfunctional Detachment, the number of years of practice by the physician, and the patient's overall health score as rated by the physician. This was only partially supported. Dysfunctional Detachment and the patient's overall health score both emerged as being significantly correlated. When the patient's overall mood score was divided into depression and anxiety, depression emerged as significant while anxiety did not. This is somewhat surprising given previous research. Goodwin, Goodwin, and Kellner (1979) found that anxiety and depression in lupus patients were both correlated with physicians' rating them as difficult. Novack and Landau (1985) also found that of the patients who were categorized as being difficult, 17% had Panic Disorder and 15% had Depression. Jackson and Kroenke (1999) also found that the presence of a mood disorder or anxiety increased the likelihood that physicians would experience their patient as being difficult. Walker et. al. (1997) found that in patients with fibromyalgia and rheumatoid arthritis, patients were experienced as being more difficult if they had dysthymia and agoraphobia.

As ratings of difficulty increased so did the patients depressive symptoms, but this trend did not apply to patients' anxiety symptoms. This could be due to the fact that these ratings were made after only a single visit with the patient and reflect only initial impressions, but it might also have something to do with the nature of the two disorders. Depression is generally associated with lower energy levels in patients, which might result in

physicians needing to exert more effort to be of assistance. An anxious patient may be shaky and unfocused, but they might have more energy to talk with their physician in order to give them the information they are requesting. These interactions may feel less daunting to the physician.

It is important to note though that the differences found between this study and other studies also may be due to the sample and methodology used. Jackson and Kroenke (1999) had a sample that was slightly older (mean age = 55 years compared to mean age = 40 years in the present study). In addition their sample was half women and half men where this study had the majority of females. Also, the physicians in their study had an average of 11 years of practice where the physicians in this study had a mean of 2.82 years. In addition to the differences in the sample, the methodology used was slightly different. Instead of looking at the overall DDPRQ score, they grouped their patients as difficult or not difficult using a score of 30 on the DDPRQ as the cut off. In addition the patients were classified as having anxiety if they met criteria for a DSM-IV diagnosis. In this study there was a two question screening instrument and instead of looking at classifying the patients as having an anxiety disorder, the number of symptoms endorsed was used.

Novack and Landau (1985) also had a sample that was equally split between men and women although the age was similar to the age in this study (mean = 41 years and mean = 40 years in the present study). However, they did not use the DDPRQ to look at difficulty ratings. Instead they used a team that consisted of an internist, a mental health professional, primary care residents, and a psychiatry resident to label patients as difficult or not difficult.

Walker et al. (1997) used a sample that consisted entirely of women. Their sample was also slightly older (mean= 51 years compared to mean = 40 years) and consisted entirely of rheumatoid arthritis patients and fibromyalgia patients. In the present study, the sample consisted of patients with a variety of health issues in a primary care clinic. The DDPRQ scores obtained in their study were normally distributed and ranged from 13 to 45. The mean was 29.3 (SD = 9.9). This is slightly different than the scores obtained in this study's sample. This study had scores that ranged from 10 to 58, and the mean was 20 (SD =8.85).

In addition, Lin et. al. (1991) found that the patients rated as being frustrating by their physician and the patients that were rated as not being frustrating by their physician did not differ on scores of their health rated by their physician. However, in our sample this is not true. The ratings of difficulty increased as patients health score as rated by the physician decreased. Sharpe et. al. (1994) found that in two medical clinics and in a surgical clinic, patients with medically unexplained symptoms or severe untreatable illness were rated as being more difficult by their physician, which could help to understand the findings in this study. When a patient has very poor health, it makes for a more complicated case, and this might be more difficult for a physician who is faced with time pressure. This study has generally less experienced physicians, and this could leave them feeling more confused when confronted with a complicated case as well as more anxious. In addition the visits in the clinic are expected to be 20 minutes including time for the patient interview, precepting, and presenting the plan to the patient for 2<sup>nd</sup> and 3<sup>rd</sup> year residents. This time is expanded to thirty minutes for 1<sup>st</sup> year residents. However, staying on time is rare in the clinic, and many times residents end up getting behind and having multiple patients waiting on them.

Hahn et. al. (1994) also found that patients who met criteria for a personality type (did not meet criteria for a diagnosis of a personality disorder but had features) in their sample constituted 44% of the patients that were identified as being difficult by the physicians. While Destructive Overdependence was not significantly correlated with physician ratings of difficulty, Dysfunctional Detachment was. Again this may have something to do with the nature of these two different personality types. In a single visit a physician may feel as if they can help someone who is interacting with them, and someone who is overdependent will be able to do this. However, someone who is detached will not be as forthcoming with information. At the end of their visit they are also less likely to behave in a way that makes the physician feel as if they valued their time and recommendations. It may also seem that a dependent patient would be more likely to actually follow the medical recommendations they gave.

Bornstein (2005) states that dependency is associated with negative factors like relationship conflict and increased physical illness, but that it is also associated with positive traits like being able to infer the attitudes and beliefs of others and the desire to perform well. In an initial visit there has not been as much time for the physician and the patient to interact and it could be that the physician has only seen the positive traits of the patient like the Destructive Overdependent patient may be able to pick up on interpersonal cues by the physician in an initial visit that would allow for them to interact in the desired manner. Healthy Dependent people have been shown to present with adaptive help seeking behavior in medical settings, and that they are able to gain the maximum benefits from medical

treatment because they display conscientious patient-related behavior and will be compliant with medical regimens (Bornstein & Kennedy, 1994; Poldrugo & Fortti, 1988).

In addition, Schwenk and Romano (1992), explain that physicians have a desire to be needed by their patients and gain satisfaction from providing care, a sense of closure and satisfaction with their recommendations, and a patient who is cooperative and appreciative. These are things that a dependent person may be able to display, but that a detached person would not. Also, a patient being destructively overdependent may not bother a physician in a single visit, but it is likely that over time the patient making repeated visits and demanding more time, would cause the physician to feel overwhelmed and thus rate the patient as being difficult. This would need to be explored in a future study where patients and physicians have developed a longer-term relationship.

Schwenk and Romano (1992) also acknowledge that there could be physician characteristics that could contribute to a difficult patient-physician interaction such as communication style, physician psychopathology, topics they find difficult to talk about, or being of a different ethnicity. Hinchey & Jackson (2001) also found that difficult encounters were created by both the patient characteristics and the physician characteristics. The physician characteristics that were associated with these difficult encounters were worse psychosocial attitudes and less clinical experience. The only physician characteristic that the present study was able to look at was the number of years the physician had been practicing medicine. This was not found to be significant, but it would be important in the future to look at a greater array of physician characteristics.



The second hypothesis that the difficulty ratings provided by the physician will be significantly and negatively correlated with healthy dependency was not supported. It seems like healthy dependent patients would be able to interact with their physician in a way that promoted health and them following the physician recommendations. Again this finding could be due to the nature of the study in that the patients may not have developed a long term relationship with their physician. It could be that once the patient had worked with their physician for a longer amount of time, the physician would be able to appreciate that the healthy dependent patients worked to follow their recommendations, did not schedule unnecessary follow-up visits, and felt comfortable with maintaining a professional distance with their physician.

The third hypothesis that Destructive Overdependence would be significantly higher in female participants than in male participants was not supported. Bornstein (2005) states that dependent personality disorder is slightly more common in women (11%) than in men (8.5%) in the general population. In addition on self-report measures, like the Relationship Profile Test used in this study, there have been higher levels of dependency found in women over men. Bornstein (1992) suggested this is due to the face validity of these measures, and that men may be less willing than women to endorse items that acknowledge their dependent traits and feelings. On the Relationship Profile Test women have been shown to consistently score higher on the Destructive Overdependence scale than men (Bornstein, 1995; Bornstein et. al., 2004). However, in projective measures of dependency women and men have been found to have similar levels of dependency (Bornstein, Leone, & Galley, 1988; Greenberg & Bornstein, 1989). In projective measures it is more difficult for men to disguise or distort

their traits and feelings. Women were only slightly higher on Destructive Overdependence than men, and not to a statistically significant degree. It could be that the men in the study were capable of acknowledging their dependent traits and feelings, or it could be that the sample contained too few men to find a true difference.

The fourth hypothesis that the mean score of Dysfunctional Detachment will be higher in the male participants than in the female participants with a small effect size, was not supported. In the past it has been found that men tend to score higher on the Dysfunctional Detachment scale but not to a significant degree (Bornstein 1995; Bornstein et. al., 2004). This is similar to the DSM-IV-TR assertions regarding gender differences when it comes to detachment. In the DSM it is stated that women and men are diagnosed with avoidant personality disorder at an equivalent rate. However, men are diagnosed more often with Schizoid personality disorder than are women (APA, 2000). Bornstein et. al. (2004) also stated that the Dysfunctional Detachment Scale were mainly reflective of male stereotypical behavior. In this study the females actually had a higher mean than the males even though it was not significant. It could be that the participants that volunteered for participation had very similar levels of femininity and masculinity, or it could be that there would need to be more male participants to see the difference.

The fifth hypothesis that the overall mood score, Destructive Overdependence, Dysfunctional Detachment, number of years the physician has been practicing medicine, and the patient's overall health score as rated by the physician would all be predictors of difficult doctor patient relationships, and that Destructive Overdependence would account for the most variance with the other variables adding to the equation, was only partially supported.

There were four predictors that emerged from the seven entered. The patient's overall health status accounted for the most variance in the equation. Research in the past has been mixed on how this contributes to physicians rating their encounter with a patient as being difficult. Lin et. al. (1991) found that physical disease was not different in the patients that physicians found frustrating versus the patients that they did not find frustrating. However, Sharpe et. al. (1994) found that there were three categories that were commonly associated with patients being rated by their physicians as being difficult, and two of these were medically unexplained symptoms and severe untreatable illness. Also, Schwenk et. al. (1989) found that one of the two factors that underlies the physicians ratings of perceived difficulty were medical uncertainty. Ericsson and Lehmann (1996) found that it takes 10,000 hours of practice to become an expert at something. The physicians in this study have less hours of practice, so it is reasonable to assume that many cases they encounter in the clinic will leave them feeling uncertain, especially the more complicated less healthy patients. In addition Hahn et. al. (1996) found that the number of physical symptoms was correlated with ratings of difficulty, but upon further examination ratings of difficulty were not associated with the most common medical disorders like hypertension, arthritis, diabetes, cardiac disease, pulmonary disease, or cancer. Instead the ratings of difficulty were more related with common somatoform symptoms. Jackson and Kroenke (1999) found that five or more physical symptoms were a significant predictor of physicians rating their patients as difficult. Given the past research results it seems that physicians rating patients with poor health as more difficult have more to do with the physicians' level of comfort in treating more complicated medical problems.

The present study was largely completed by dyads of patients and residents, and given that residents are still in training, these patients may seem more complicated to beginning physicians and may cause them to feel more overwhelmed than a physician who has had more experience in working with patients.

Destructive Overdependence accounted for 22% of variance in the equation, but surprisingly it was in the opposite direction than expected. This means that the more Overdependent the patient was, the less difficult the physician found them. Hahn et. al. (1994) found that the patients who were described as being demanding and irritating had significantly higher DDPRQ ratings. It seems like a Destructively Overdependent patient would be demanding of the physicians' time. However, Schwenk and Romano (1992) state that physicians have a desire to be needed by their patient, and they get their satisfaction from providing care. A patient who is overdependent is going to appear to need the physicians, and they may also seem more compliant. Given that these ratings were made after a single visit, it might be hard for a physician to really become frustrated by a Destructive Overdependent patient. The aversive aspects of Overdependence are likely to manifest over time. The negative experiences of the physician with these patients would be a byproduct of the patients making repeated demands. In addition, the clinic where the study took place has utilizes what is called phone duty. This means that the 2<sup>nd</sup> or 3<sup>rd</sup> year resident in the clinic that half day with the least number of patients responds to all patients phone requests during that half day. This means that dependent patients who make repeated phone calls may not be talking directly to the physician who made the ratings of difficulty. Thus the residents may only see the positive behaviors of more destructive overdependent patients and not the

negative since another physician in the clinic may be the one to respond to their repeated demands.

Depression was the second variable to add to the equation. This result is not surprising. Goodwin, Goodwin, and Kellner (1979) also found that depression was strongly associated with ratings of difficulty. Novack and Landau (1985) also found that 15% of the patients who were rated as difficult by their physician had Major Depressive Disorder. Walker et. al. (1997) found that dysthymia was associated with patients being rated as difficult by their physicians. Schwenk and Romano (1992) explained that many patients that are rated by physicians as being difficult have an undiagnosed mental illness which affects how they are able to communicate with their physicians. This would explain why depression would be strongly associated with ratings of difficulty and why it would be a significant predictor of difficulty ratings since a patient who is depressed would not have the energy to be forthcoming with information that the physician is trying to gather. They also may appear to not appreciate the physician's time and look as if they would be unlikely to follow through on the physician's recommendations. It is also important to note that depression has many somatic symptoms such as sleep disturbance, increased appetite or decreased appetite, etc that might make it difficult for physicians to make a differential diagnosis. Again this might leave them feeling frustrated over the complexity of the case or as if they have to spend more time with the patient even though they are feeling pressed for time.

Hahn et. al. (1996) used a forward regression analysis to assess the predictors of a difficult relationship between physicians and patients, and in this equation the number of mental disorders emerged as a significant predictor. The only two Axis I disorders included in this

study were depression and anxiety. It would be interesting in the future to see if other Axis I disorders would also be predictors of difficulty ratings by the physician. Jackson and Kroenke (1999) used a logistic regression equation and found that the presence of a mood or anxiety disorder was a significant predictor of difficulty relationships. The present study produced somewhat different results since anxiety did not emerge as a significant predictor, but depression is similar to their finding that a mood disorder was a significant predictor.

The final variable that added to the equation was dysfunctional detachment. A person who displays more detached behaviors is going to have more difficulty in being forthcoming with information with physician in their encounters. They will probably not be as quick to provide information the physician is asking for, and they will also appear to not be someone who is going to follow the physician's recommendations. They might even appear to not like the physician.

Past research has not specifically addressed how detachment is related to difficult encounters. However, Sharpe et. al. (1994) found that one of the three most common categories that emerged as being significantly related to ratings of difficulty by the physicians was social problems like communication difficulties, poor relationships, etc. It is reasonable to assume that a patient who is detached would have some social difficulty. Schwenk et. al. (1989) also found interpersonal difficulty to be strongly associated with physician's ratings of difficulty. Again a person who is detached is going to have some interpersonal difficulty because they feel that others are untrustworthy and have a fear of being hurt or overwhelmed by others. While Dysfunctionally Detached people may not typically show interpersonal difficulty because they keep from engaging in relationships, in

this study they are in a situation where they must interact with someone. This may make them feel extremely uncomfortable.

Walker et al. (1997) assessed personality characteristics that were associated with difficulty ratings. Worry, Tension, Loneliness, and helplessness were all positively correlated with difficulty ratings. A detached person may possess some of these characteristics like being worried about being hurt or overwhelmed by another person, and feelings of loneliness because they do not allow for others to get close to them. Hahn et al. (1994) found that 44% of their patients that were identified as being difficult in their sample met criteria for a personality type and 12% for a personality disorder.

The sixth hypothesis that patient's ratings of perceived difficulty in working with their physician would be significantly related to the overall mood score, Destructive Overdependence, Dysfunctional Detachment, Number of years of practice by the physician, and the patient's overall health score as rated by the physician, was only partially supported. The only one of these variables that emerged as being significant was the number of years of practice by the physician. This is somewhat surprising given that in this study the ratings of "difficulty" by the physician were correlated with several study variables. However, the PDRQ is a new measure and patient's ratings of a difficult relationship have not been studied as much as physician's ratings. Hinchey and Jackson (2011) found that one of the physician characteristics that were associated with difficult relationships was less clinical experience. This makes sense due to the fact that patients are going to be able to pick up on whether their physician feels comfortable and confident in their role or not. Less experienced physicians are more likely to appear nervous and less structured. The residents in our study included

first year residents just beginning their training experience. Not only do these residents have less experience and may not seem as comfortable in the room with their patients, but they are also relying more on the attending physicians to help them. This means the patients' visit may take much longer than expected. The clinic has a policy that, during the first month of residency, the attending physician must come into the room with the beginning resident after they have interviewed the patient and discussed the care with the attending physician. This ultimately leaves the visit lasting much longer than the 20 minutes that are scheduled. This all can leave the patient feeling dissatisfied with their encounter. In the future it will be interesting to look at the patient's ratings of difficulty and what factors are related to those. In addition, it is likely that the patients can pick up on the fact that the resident physicians are less skilled, and it is reasonable to assume that residents might make procedure errors that leave the patient with more physical discomfort since they are less experienced in procedures.

The seventh hypothesis that patient's ratings of perceived difficulty in working with their physician would be significantly and negatively correlated with Healthy Dependency was not supported. This is somewhat surprising. Healthy Dependent people have flexible, situation-appropriate, help and support seeking behaviors. They are both outgoing and agreeable, and secure and socially competent (Bornstein, 2005). In addition, due to their combination of autonomy and connectedness, they display more adaptive medical help seeking (Bornstein et. al., 2002). It seems that this would allow for less problematic and better doctor-patient relationships. Results may have been different if patient-physician dyads were only included in they had developed a relationship by working together multiple times.



The eighth hypothesis that Anxiety, Depression, Destructive Overdependence, Dysfunctional Detachment, the patient's overall health score as rated by the physician, and the number of years the physician has been practicing medicine would all be predictors of the patient's perceived difficulty in working with their physician, and that Destructive Overdependence would account for the most variance was not supported. Given the results of the Pearson correlation matrix that was run to look at the correlations between the patients' ratings of difficulty and the other variables, this is not surprising. In the model it is only the number of years the physician has been practicing medicine that is a significant predictor. Patients may be quick to pick up on the physicians that seem to be less competent and confident. This could lead to some trust issues since patients trust their health with their physician. In addition, the less competent the physician is the more time they are going to need to spend with the patient. Longer visits may be frustrating for patients who are busy.

The ninth hypothesis that the DDPQR scores provided by the physician and the PDRQ scores provided by the patient would be significantly and negatively correlated was supported. The PDRQ is a new measure which has not been studied to a great extent. This provides support for the PDRQ's validity.

Age was significantly correlated with both the patient's overall health status as rated by the physician and the DDPQR scores. It is not surprising that the patient's overall health would be related to age. It seems that the older people get the more likely they are to have complicated medical problems. It is also reasonable then that the DDPQR scores were significantly correlated with age since the patient's overall health status was the predictor that accounted for the most variance in the equation. However, this then led to the question of

how age would mediate the relationship between the predictors and the DDPRQ scores.

When age was entered into the path analysis it appears to be mediating the path between not just the patient's overall health statuses in predicting the DDPRQ scores, but also mediating the path between the years of practice a physician has in predicting the DDPRQ scores. This was an interesting finding, but it could be that the older patients are choosing physicians that seem competent and confident in handling their medical problems. This might lead to some of them favoring the attending physicians or the third year residents who have had more experience. It could also be that patients who are older may have more complicated health problems feel more comfortable and understood by a physician who is closer to their age, which would then leave them choosing to work with physicians who have more years of practice. Thorton et. al. (2011) found that the patient and the physician sharing similar characteristics like age, race, and gender affected the patients' perception of care. When there is a low concordance rate the patient has a less positive perception of their healthcare. It is also important to remember that patients are allowed to choose their physician; however, attending physicians will try to move their patients to residents so that the residents get more experience. In addition, right before the study took place several physicians graduated the residency program and assigned their patients to new physicians. Also, physicians only work on a specific day or two days. If a patient needs a visit the day they call in, they will most likely need to see a different physician.

### **Study Limitations**

The demographics of the patient population are not surprising given the clinic where the study took place. This is a clinic that provides services to many economically challenged

patients. However, it is important to note that the results from this study may only be applicable to patients who fit this demographic profile. In addition it is also important to note that ratings of difficulty were made after a single visit, and it was not necessary that the patient have seen their physician multiple times before participating. Results may vary if the patient has developed a long-term relationship with the physician since Hahn et. al. (1996) found that patients who were not all known by their physician before their appointment were less likely to be experienced as difficult by their physician than patients who were somewhat known and not at all known by their physician. It is also important to remember that while the clinic does allow patients to select the physician they will see, if the physician they choose is an attending, they are often switched to a resident physician unless they have had a long term relationship with the attending physician. In addition, residents and attending physicians are only in the clinic on certain days of the week. If one of their patients calls and needs to be seen right away on a day their physician is not there, then the patient is scheduled with another physician. Along with that, the study took place right after several residents graduated the program, and when this happens the graduating resident refers their patient to one of the other residents in the clinic. While some patients may have chosen their physician they saw in this study, many may not have had a choice.

The study is limited to patient factors of Axis I and Axis II pathology and not both patient and physician factors. Physicians' amount of training was considered, but the physician might have an Axis I or Axis II disorder that could also contribute to the difficulty experienced between the patient and the physician since difficult interactions is a function of both doctor and patient characteristics. There might be other physician characteristics that

could come into play in creating a difficult doctor-patient relationship like communication skills, ethnicity, gender, etc. Reports of patient difficulty level were only provided by physicians. There is no outside observer rating of the degree of difficulty. However, the DDPRQ has adequate reliability and validity as a physician rating form (Hahn et. al., 1996).

In addition to this, this study took place at one specific clinic which places some constraints on the generalizability. Along with this, the participants volunteered for this study. It is unclear on how the role of volunteering might play when trying to assess difficult patients. There could have been some degree of self selection that influenced the results obtained, but providing the volunteers with a gift card for their participation could have helped to encourage all patients regardless of being difficult or not, to volunteer. Also, the results from the study are only limited to an adult primary care population, and the study does not ensure representations of various ethnicities. In addition to this Dependency was only assessed via a self report measure rather than a multi-method assessment (e.g. self-report and projective assessment). However, if a multi-method assessment was used it would be much more time consuming for the researcher and the participants, and this might affect who volunteers for participation. Along with that, physical illnesses were not being included in the study, which could also play a role in the difficult doctor-patient relationship.

This study was also limited in the fact that it only included patients who do not have a guardian or translator who comes with them to the clinic. Thus only patients who speak English were included in this study. This reduced the amount of diversity in the study.

Another limitation of this study is that there was an overall score of the patient's health as rated by the physician. In past studies they have been able to look at each individual

diagnosis made by the physician in the patients' health records. Unfortunately the researchers did not have access to the electronic medical records to be able to do this. Given the fact that the physician is the one making the ratings of the overall patient's health there could also have been some bias. Also, reliability and validity of this measure is not available.

Another drawback of this study is that the patient has interactions with multiple staff members beside their physicians (i.e. medical assistants, front desk staff, attending physicians). This could have affected the patient's ratings of their visit with their physician even though the patient was instructed to only rate their visit with their physician.

Future research should be done to better understand how personality pathology will influence difficult doctor-patient relationships. This study only included Destructive Overdependence and Dysfunctional Detachment. There are multiple other Axis II personality disorders that will need to be understood. In addition, it will be important that future studies look at difficult doctor-patient relationships with physician-patient dyads that have a longer term relationship. It is suspected that there would be other factors that influence these difficult relationships rather than the factors that influence difficult relationships based on a single visit.

Future research should also be done to fully understand what physician variables influence a difficult doctor-patient relationship. This study only included the number of years of training each physician had. It would be useful to also look at personality traits, Axis I disorders, ethnic matching, and communication styles.

In addition, future research is needed to examine what influences a patient to rate a visit as being difficult. The measure used in this study is new, and very few studies have used

it thus far. This study only found one variable related to it, but it is likely that there are others.

### **Clinical Implications**

In the future it will be important to develop a more comprehensive training program for Family Medicine Residents on how to work with depressed patients. It is also important to help educate and enable physicians to feel more comfortable working with patients who are more detached. In addition it is important to help beginning physicians to develop skills so that they seem as competent and confident as older physicians. It might be worthwhile to have beginning residents practice consultations with actors who portray either a depressed patient or a detached patient so that residents are able to better work with these types of patients when they come into the clinic. In addition by practicing with actors, residents will have time to better acquaint themselves with the procedures in the clinic like the use of the electronic medical record, what the role of the Medical Assistant is, etc. This will allow for them to appear confident in their appointments with their real patients.

## **Appendix A**

## Appendix A- Physician Questionnaire

Please rate (“X”) the following based on today’s visit with your patient.

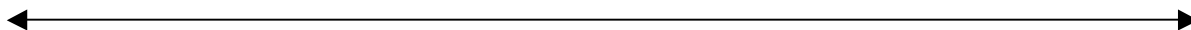
1= Not at all

6= A Great Deal

1	How much are you looking forward to this patient’s next visit after seeing this patient today?	1	2	3	4	5	6
2	How “frustrating” do you find this patient?	1	2	3	4	5	6
3	How manipulative is this patient?	1	2	3	4	5	6
4	To what extent are you frustrated by this patient’s vague complaints?	1	2	3	4	5	6
5	How self-destructive is this patient?	1	2	3	4	5	6
6	Do you find yourself secretly hoping this patient will not return?	1	2	3	4	5	6
7	How at ease did you feel when you were with this patient today?	1	2	3	4	5	6
8	How time-consuming is caring for this patient?	1	2	3	4	5	6
9	How enthusiastic do you feel about caring for this patient?	1	2	3	4	5	6
10	How difficult is it to communicate with this patient?	1	2	3	4	5	6

Please rate how healthy your patient is overall with 0 being extremely unhealthy and 100 being extremely healthy.

0-----10-----20-----30-----40-----50-----60-----70-----80-----90-----  
100





## **Appendix B**

## Appendix B- Relationship Profile Test

Please use the following scale to rate each of the statements below. If a statement is very true of you, you'd circle a high number, like 4 or 5. If a statement is not at all true of you, you'd circle a low number, like 1 or 2.

1 2 3 4 5

Not at all true of me Very much true of me

1. Other people seem more confident than I am.	1	2	3	4	5
2. I am easily hurt by criticism.	1	2	3	4	5
3. Being responsible for things makes me nervous.	1	2	3	4	5
4. I am most comfortable when someone else takes charge.	1	2	3	4	5
5. Others don't realize how much their words can hurt me.	1	2	3	4	5
6. It is important that people like me.	1	2	3	4	5
7. I would rather give in and keep the peace than hold my ground and win an argument.	1	2	3	4	5
8. I am happiest when someone else takes the lead.	1	2	3	4	5
9. When I argue with someone, I worry that the relationship might be permanently damaged.	1	2	3	4	5
10. I sometimes agree with things I don't really believe so other people will like me.	1	2	3	4	5
11. Other people want too much from me.	1	2	3	4	5
12. When someone gets too close to me, I tend to withdraw.	1	2	3	4	5
13. I need to escape from it all every once in a while.	1	2	3	4	5
14. I wish I had more time by myself.	1	2	3	4	5
15. I prefer making decisions on my own, rather than listening to	1	2	3	4	5

others' opinions.					
16. I don't like to reveal too much personal information.	1	2	3	4	5
17. I'm sometimes wary of other people's motives.	1	2	3	4	5
18. I'm happiest when I'm working on my own.	1	2	3	4	5
19. Being independent and self-sufficient are very important to me.	1	2	3	4	5
20. When things aren't going right, I try to hide my feelings and to be strong.	1	2	3	4	5
21. I believe that most people are basically good and well-meaning.	1	2	3	4	5
22. I am able to share my innermost thoughts and feelings with people I know well.	1	2	3	4	5
23. I am comfortable asking for help.	1	2	3	4	5
24. I don't worry about how other people see me.	1	2	3	4	5
25. Most of my relationships involve give-and-take, with both people contributing their share.	1	2	3	4	5
26. My relationships are pretty much the way I want them to be – even if I could, I wouldn't change things.	1	2	3	4	5
27. I see myself as a capable person who copes well with disappointments and setbacks.	1	2	3	4	5
28. In my relationships. I am comfortable offering support when the other person needs it, and asking for support when I need it.	1	2	3	4	5
29. When I have a falling-out with someone, I am confident that the relationship will survive.	1	2	3	4	5
30. It is easy for me to trust people.	1	2	3	4	5

## **Appendix C**

## Appendix C- PHQ-4

**Over the last 2 WEEKS, how often have you been bothered by any of the following problems?**

box Place an "X" in the appropriate

	Not at all	Several days	More Than half the days	Nearly every day
a. Little interest or pleasure in doing things	[ ]	[ ]	[ ]	[ ]
b. Feeling down, depressed, or hopeless	[ ]	[ ]	[ ]	[ ]
c. Feeling nervous, anxious, or on edge	[ ]	[ ]	[ ]	[ ]
d. Not being able to stop or control worrying	[ ]	[ ]	[ ]	[ ]

## **Appendix D**

## Appendix D- PDRQ- 9

Please Rate Your Encounter with your physician today

1= Not at all agreeing 2= Somewhat agreeing 3= Agreeing 4= Mostly Agreeing

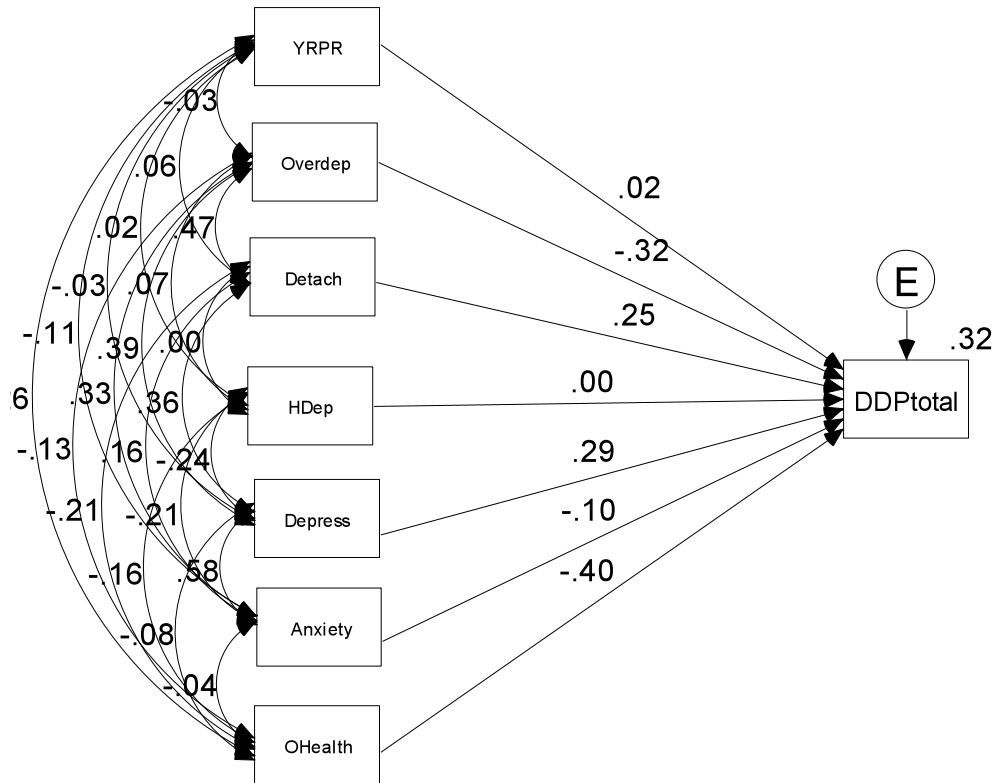
5= Totally Agreeing

1. My PCP understands me	1	2	3	4	5
2. I trust my PCP	1	2	3	4	5
3. My PCP is dedicated to help me	1	2	3	4	5
4. I can talk to my PCP	1	2	3	4	5
5. I feel content with my PCP's treatment	1	2	3	4	5
6. My PCP helps me	1	2	3	4	5
7. My PCP has enough time for me	1	2	3	4	5
8. My PCP and I agree on					
the nature of my medical symptoms	1	2	3	4	5
9. I find my PCP easily accessible	1	2	3	4	5

## **Appendix E**

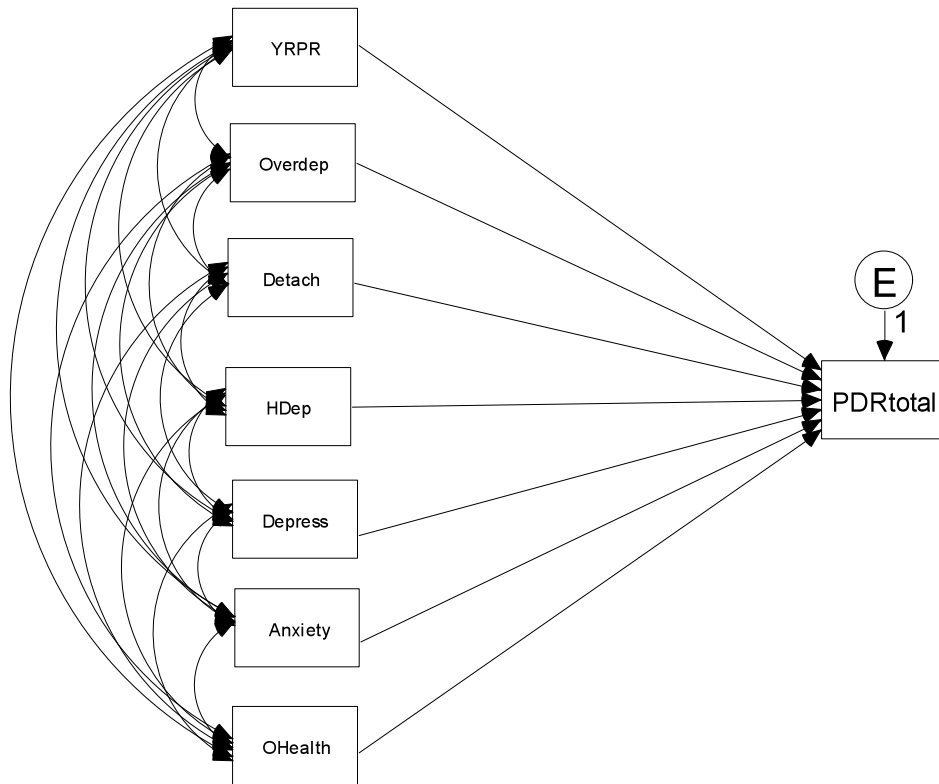


## Appendix E – Model of DDPRQ Regression



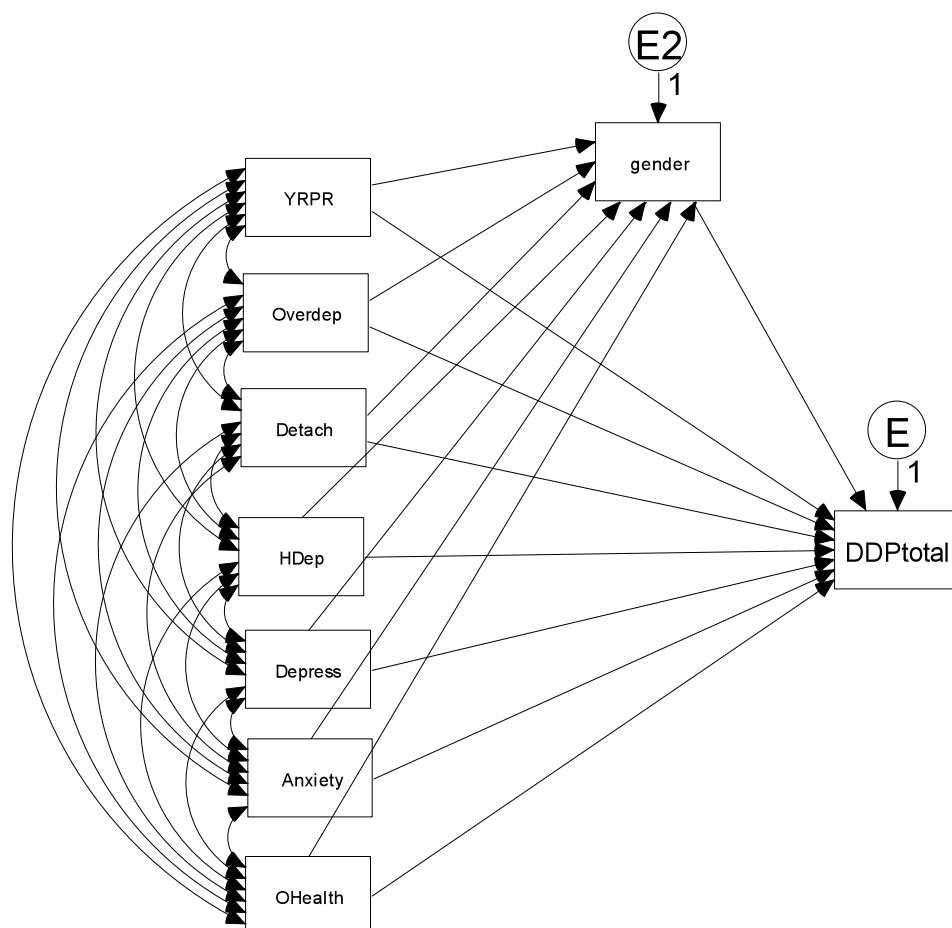
## **Appendix F**

## Appendix F – Model of PDRQ regression



## Appendix G

## Appendix G- Path Model with DDPRQ



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## ABSTRACT

DEPENDENCY, PSYCHOPATHOLOGY, AND DIFFICULT DOCTOR-PATIENT  
RELATIONSHIPS IN PRIMARY CARE PATIENTS

By

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Strong relationships between physicians and patients can increase treatment effectiveness and result in better outcomes. Dissatisfying relationships between doctors and patients can have significant negative consequences. Difficult patients are higher utilizers of health care services, more dissatisfied with their care, contribute to physician burnout and dissatisfaction, and have poorer treatment outcomes. Dependency is also related to patients' health with dependent and detached individuals being more likely to have mild short-term illnesses, more serious illnesses, and be higher utilizers of health care. Adult patients (N = 101) from a family medicine residency clinic provided ratings of pathological and healthy dependency, detachment, depression, anxiety, and satisfaction with their provider. Physicians (N = 18) rated patients' overall health and degree of patient difficulty. Difficulty ratings of patients were significantly correlated with detachment ( $r = .26$ ), depression ( $r = .23$ ) and health status ( $r = -.42$ ). In a regression analysis, detachment, pathological dependency, depression, and health status emerged as significant predictors ( $p = .001$ ) and accounted for

32% percent of the total variance. Although the patients ratings of satisfaction with their providers were significantly correlated with the number of years that their physician practiced medicine ( $r = .21$ ), the overall regression model was not significant. In an exploratory path analysis, age was entered into the model and emerged as a partial mediator through its relationship with patient health status ( $p < .001$ ), the number of years of practice by the physician ( $p < .05$ ), and the ratings of difficulty provided by the physician ( $p < .001$ ). The degree of patient difficulty as rated by the physician was predicted by patient health status, degree of patient detachment, severity of depression, and pathological dependency (albeit in the opposite direction). These findings suggest that patients who are in poorer physical health and who have psychological traits and symptoms that lessen their ability to effectively communicate their difficulties are experienced as being more difficult by their physicians. Patients' satisfaction with their physicians appears to be associated with years of experience that their physicians have obtained.

### **Autobiographical Statement**

Shannon Leigh Fowler is originally from Houston, Texas. She obtained her Bachelors of Science from Eastern Michigan University with a major in psychology and a minor in nutrition. She began attending the University of Detroit Mercy in the fall of 2007 in the Clinical Psychology PhD program. Her second year project was done on her primary care practicum site at Crittenton Wayne State Family Medicine Center as is entitled *Eating Disorders, Depression, and Abuse; A Primary Care Sample*. She has spent three years working with Dr. John H. Porcerelli and the Wayne State Family Medicine Residency Program where she also collected data for her dissertation. Past publications include *The relationship of body image to body mass index and binge eating: the role of cross – situational body image dissatisfaction versus situational reactivity* (Saules, Collings, Wiedemann, & Fowler, 2009. and *Behavioral interventions by residents during collaborative encounters* (Porcerelli, Fowler, Murdoch, Sklar, Wright, Klassen, & Morris, 2013). She plans to continue her work in family medicine residency, and she will be completing her internship within the Alaska Psychology Internship Consortium with her main placement at the Providence Family Medicine Residency Clinic in Anchorage.