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Case Study

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Virtual Acute Stress Reaction in a Treatment Team Following a Family Meeting of "Potentates": Measures of Prevention

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ABSTRACT

Background: Volumes have been published on "difficult" patients and their representatives; however, there is sparse literature available as to how a "difficult" patient or a provocative family encounter is experienced by a team of members across various disciplines, associated with the treatment. We report a case to present our experience with "potentates", a type of "difficult" client, which could help draw suggestions to allow for prevention in more generalized situations.
Objective: To identify strategies that would help avoid occurrences and minimize the negative impacts possibly associated with the responses of the "potentates" towards the treatment team.
Method: The medical case of a 21-year-old female inpatient with provocative psychopathology was presented, initially evoked as a reaction towards her family followed by a state of intense anger and a tendency of being accusatory towards the treatment team during a family meeting. The patient's response thus led the members of the treatment team to experience signs and symptoms commonly associated with virtual acute stress reaction (ASR).
Results: We analyzed the outcome of the interaction between the patient and the treatment team during the meeting, reviewed the literature relevant to pre-existing research in this domain, and concluded that there could be possible helpful strategies and measures that could be implemented in family meetings to prevent the possibility of virtual ASR. This case report paves the path for further research to ensure the protection of multidisciplinary teams under various clinical settings.
Discussion: A treatment team is potentially vulnerable to physical, verbal, psychodynamic and other commonly implemented modes of attack from patients and their representatives. Appropriate measures need to be implemented with the objective to prevent and minimize the effect of these attacks on the treatment team.

KEY WORDS: Potentates; Projective identification; Acute stress reaction (ASR); Family meeting; Dynamics.

ABBREVIATIONS: DSM IV: Diagnostic and Statistical Manual of Mental Disorders Fourth Edition; PCD: Patient Care Director; ASR: Acute Stress Reaction.

INTRODUCTION

We present a unique aspect amidst the availability of abundant literature on "difficult" patients (referring to the ones with specifically borderline and/or narcissistic pathology) and their representatives. In this article, we discuss a group phenomenon with symptoms similar to that of acute stress disorder experienced by the members of a multidisciplinary treatment team.

The common symptoms of acute stress disorder are associated with numbing; detachment; derealization; depersonalization or dissociative amnesia; continued re-experiencing of

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the event *via* thoughts, dreams, and flashbacks; and avoidance of any stimulation that evokes memories of the event (Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM IV)).[1] This clinical picture is described in the context of dealing with a "difficult patient", referring to a patient whose behavior seems to challenge the clinician in a negative way, evoking negative countertransference, thereby making it difficult for the physician or the staff to empathize with the patient and/or their even more "difficult" family. The challenges posed while providing therapeutic care to "difficult" patients in different medical settings have been thoroughly studied and well described by various researchers. A particularly useful categorization describes them as either Special, VIP or "potentate" patients. The latter are also referred to as the "want to be celebrity patient.[2] However, there have been no evidences of research on the psychological and emotional trauma such cases can have on the multidisciplinary treatment team. Consequently, there is a lack of available information on preventive measures, concrete steps and dynamic strategies to minimize the occurrence as well as the impact on the treatment team. In the present study, we discuss in detail our experience with the difficult patient and propose the general principles of prevention and management for a multidisciplinary team of clinicians.

CASE PRESENTATION

The patient, a 21-year-old female, the only child and a student at an out-of-town college, was admitted to our inpatient unit for the treatment of depression and anxiety showing a voluntary status. The symptoms worsened when the patient was subjected to different social situations, and consequently resulted in a state of passive suicidal ideation. She complained that she was unable to find an antidepressant to effectively address her symptoms. The patient denied a history of suicide attempts or self-injurious behavior. Following her admission to the unit, the psychiatrist interviewed the patient. The patient while sharing her life experiences mentioned that she had a very close relationship with her mother, which according to her speculation kept her from developing healthy interpersonal relationships with her peers.

As the interview progressed, the patient became more agitated and was losing her focus from the conversation, expressing greater frustrations with the passage of time. She reportedly experienced a feeling by virtue of which she could not count on any firm structure. She complained that she did not have access to her inpatient multidisciplinary treatment team members as often as she desired, and they could not give her the answers she sought as quickly as she expected (entitled). The patient continued to meet with the team in the mornings and with her mother and the social worker in the afternoon. Initially it seemed as though overall the patient and her mother were content with the treatment as there were no visible signs of dissatisfaction and anger which developed rather suddenly with time.

Three days following hospitalization, the patient's father called the unit chief angrily demanding a family meeting. The unit chief met with the team: the psychiatrist, social worker, and the patient care director (PCD) who was the senior nurse supervising the operations of the unit. The complaints made by the family members of the patient varied from the lack of unit structure, lack of answers to questions based on prognosis, and the most significant reason was the "lack of adequate treatment", which resulted in no improvement in the patient's condition. Together, the medical faculty called the patient's father and arranged for a meeting on the same morning, insisting that the mother of the patient also be present. The unit's multidisciplinary clinical team started the meeting without the PCD. The meeting commenced with a 3-5 minute long narration by the father about the family's anger and frustration with the treatment. As the unit chief began to respond to the father, the mother interrupted (pointing her finger to his face) demanding the unit chief to "shut up" and listen attentively as she proceeded to accuse the team and the unit for various shortcomings, such as poor management of the unit by PCD and the unit chief, the lack of unit structure, a poor quality of group therapy, inadequate medical/psychiatric attention provided for her daughter by the social workers and the attendants. Both the parents were belligerent and demeaning towards the members present from the team. The rest of the meeting proceeded in an emotionally charged atmosphere. After about 30-45 minutes, the PCD joined the meeting and was similarly reprimanded by the mother. When the patient was called in to join the family meeting, to the team's astonishment, she picked up where the mother left off. Supported by her mother who looked on in an admiring manner, the patient enumerated the imperfections of the psychiatrist and the unit in a distorted, demeaning, and abusive manner. Finally, when the patient began to talk about the other patients in an unacceptable way, the meeting was ended.

Aware of the impact that the meeting had on each of the team members, a series of 2 processing sessions was conducted by a senior faculty group dynamicist for the members of the treatment team.

The team reassembled to discuss the proceedings of the meeting and the emotions, and dynamics of the behavior and performance of each team member. We decided to organize a session with an experienced group dynamicist. Two (1-hour) weekly sessions were allotted for conducting the family meeting. The group also gave their consent to record our experience as a case report.

DISCUSSION

Inpatient clinical teams conducting meetings with families or visitors are generally always vulnerable to the full spectrum of attack: violent, physical, verbal, psychological or reputational (*via* subsequent letters to the social media or administrators). We have presented a case where all the members of the team experienced only one form of this attack and yet the team found inadequate information on ways to understand and prevent a related incident from taking place in the future. Thus, the goal of this report is to review and present the various measures that could be possibly adopted to prevent avoid the inpatient clinical

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team from experiencing such vulnerabilities.

Clearly, the attack on the team in the discussed case was not physical and could rather be addressed as a verbal attack directly addressing the various team members. Furthermore, the attack was effective considering the fact that it took place in a family meeting that allowed group dynamics to play a role in it. Thus, to derive the maximum information from this case, a best effort (albeit speculative) analysis of the process was sought and obtained from Dr. Howard Kibel. Apart from being an expert group dynamicist,[3,4] he is a consultant with the hospital and is knowledgeable of the various personalities and overlapping systems of the hospital.

Genesis of Psychodynamic Ammunition

All the team members were intensely affected by the verbal attack of the mother, and the mother-daughter/patient dyad directed towards the clinical follow-up later in the meeting. The group discussions that were held with Dr. Kibel helped us understand the mechanisms that possibly led to a similar situation.

The point worth noting here is that the patient narrates a history of her close relationship with the mother, which suggests that their relationship was symbiotic. If that is so, it may serve to explain why the mother was calm and even ingratiating when she met the social worker alone, in the absence of any other family members. Ironically, while we made an effort to avoid "splitting" by insisting on having the mother present in the meeting, we actually invited more trouble. Indeed, the mother's behavior turned belligerent in the family setting. While we had our guard up for the overt anger of the father, we unwittingly lowered our guard for the covert anger of the mother.

Though speculative, this incident suggests that the setting of the family meeting mirrored the patient's behavior exhibited in the unit. The power was in the hands of the patient to control the dynamics of the family through her symbiotic association with her mother, and perhaps with her father as well. Projective Identification may have been implemented by the family, which in turn might have induced untoward feelings in the team. This family projected hatred towards the team instilling in them a sense of anger and guilt for the people they wanted to help. Such ambivalence was the cause leading to an essence of conflict.

Projection may be considered in different forms. What the patient and the family projected to the team were internal images and related effects which they found as intolerable. Our experience, in a perverse manner, may be dubbed fortunate, in that it exemplifies a classic projective identification. The experience serves as a model to define the purposes of our discussion. In the psychoanalytical and the analytically-oriented group psychotherapy literature, the term, "difficult patient", often refers to a patient with narcissistic and/or borderline pathology. This we suspect is true of the patient and the mother. Their posture in the meeting strongly resembled the "potentates" described by Groves et al[1], in this particular case meaning that the family portrayed themselves as wealthy and connected with influential people who were in charge of the hospital, which caused profound psychological impact on the team.We suspect that the complaints by the family concerning the lack of leadership and structure of the inpatient unit was a metaphor for the patient's lack of order/coherence within herself, better addressed as identity confusion, which is precisely what the team experienced.

We discovered that there has been inadequate literature and thereby information available discussing the various effects that the presence of "potentates" exerted on the treatment team. Consequently, there exists insufficient literature as well as preventative measures and strategies, which could be implemented by teams, who might find themselves in difficult family meetings. Hence, in this study, we have focused on the extent and the duration of psychological trauma experienced by the treatment team. While the patient and the family were not particularly famous, important or physically menacing, the behavior of the mother and father evoked shared emotions among the clinicians in the treatment unit. Some of the members experienced specific emotions uniquely, while some emotions were felt commonly, but in varying degrees at different time points in the episode. These include: shock, anger, fear, shame, frustration, confusion, anxiety, hatred and guilt.

Acute Stress Reaction shown by the Team

Days after the family meeting, the team talked about the recurrent and intrusive distressing recollections of the event, including images, thoughts, and perceptions. There was a sense of helplessness among the members having been subjected to this situation of intense emotional abuse as this. Each time one stepped into a family meeting we could not help but wonder if we would be subjected to the same situation, or have to relive through such distressing events all over again. For the subsequent patients who were perceived as potentially difficult patients, the team went extra lengths and put in immense efforts to avoid any occurrence of such possibly disastrous family meetings. Days after the family meeting, the team members experienced great difficulty with sleep, irritability and at times outbursts of anger.

The rush of emotions and thoughts that one undergoes in these traumatic situations are relentless. One needs to learn to first recognize the automatic defenses to be able to deal with a similar situation such as when the patient suggests "I will not be treated that way; I do not deserve this." If one is vulnerable towards getting angry or hurt, it can be considered as an easy "trap" "set" by the difficult people.

How can we protect ourselves from verbal abuse and insult in advance? Often, during the time of attack, it is hard to stay rational and remember to think: "don't engage in this struggle with an unproductive consumption of time and energy". We have to remember who we are dealing with, then remember

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to ask ourselves: "Is it worth engaging in this struggle?" How quickly is the session going to turn into a power struggle? "Are we 'really' going to change the person's opinion, or are we setting ourselves up for more criticism. Worst would be: "are we becoming 'a difficult person'?" It is obvious that some of us asked these same questions in our minds during and even days after the meeting.

And then lastly, the additional layer of difficulty is on account of the pressure that is exerted from the administrative point of view (real or imagined). With respect to the context of the meeting, when one is dealing with a presumed VIP patient or family, fantasies about the possible reaction of the administration always come into play. Members of the treatment team inevitably feel that they are under scrutiny and subject to criticism. This adds to the feeling of helplessness and vulnerability. This realization can evoke a sense of mastery among the patient and their respective family before going into the session.

Preventive Measures

We aim to start a dialogue about the ways the multidisciplinary clinicians might prepare for "attacks" in various forms during group settings such as the family meeting. Once again, the availability of related literature is limited and outdated and needs to be adopted with respect to present day conditions.

CONCRETE MEASURES

Physical Safety

Violence and physical attacks are possible incidents which can occur in any meeting. Some healthcare facilities do not screen the visitors for the possession of metal ware and weapons. All efforts should be made to clearly convey to the visitors, the facility's rules concerning the possession of weapons and firearms. Intoxication in visitors also needs to be addressed. Finally, in terms of physical safety, one must assume that some visitors may violate these restrictions or, may use their own bodies to attack the team members in the meeting, for which the room must be fitted with an alarm to security as a minimum requirement. A concrete measure to be implemented would thus be the installation of a Crisis Alarm Security Button. This measure was further renewed during the processing sessions during which it was considered that the setting for Family meetings should support facilities to encounter physical threats and enable the access to security.[5,6]

Setting the Agenda and a tentative flow of discussion: Early Preventions

For every meeting there needs to be sufficient pre-planning so that the clinicians will be prepared with strategies that both address and manage the needs of the patient and the family in accordance with the clinical recommendations. The team needs to interact with the family members about their expectations and goals prior to the meeting. A scheme of 2 major categories may be considered: a) Is the underlying impetus for the meeting to "vent" frustration? or, b) Is it to discuss concrete complaints and issues such as medications, aftercare plans, and come up with solutions? Often it would be a combination of both but a preponderance of one. Next, the clinical team must meet first to discuss the family profile and analyze the expected dynamics. Then, the family and the clinical goals of the meeting will be set and a decision will be taken determining "What will success look like". That would assure the team members of achieving clearer goal and outcome.

The agenda is then developed with: 1) The approximate amount of time to be spent on each topic; 2) Establishment of Group Norms; 3) Roles for the session will need to be specific: a) choose the facilitator who will specifically deal with process issues, arguments, agreements, and redirect the targeted group back to their goals and agenda; b) assign someone to take notes and write agreements/plans on flip chart if appropriate; c) decide who will take the lead regarding being engaged in discussing about each part of the case. Also, the team needs to agree on how the decisions will be made among the clinical staff of the meeting: Unit chief alone, consensus, or deferring to discuss within the team without the family.

"Interventions" and Exit Strategies

It is imperative to agree to the implementation of "preventive measures" as listed above instead of having to use "interventions" when the group has already become contentious. It is more difficult to bring the group back to follow the appropriate group norms when out of control. This demands the application of the right skills and practice in the right situation but can bridge the gap between a productive meeting and a poor outcome. A strong facilitator can be your best ally in these situations. The clinical staff must decide ahead of time when and how to stop the meeting, particularly if the family and/or patient becomes abusive. The use of a "time out" or a break for 5 minutes to allow a cooling off period and a chance for the clinicians to discuss a strategy which could also be helpful. If the family continues to be disruptive, the assigned decision maker can end the meeting and reschedule it to another time. However, a situation as this has a greater potential to cause family agitation thus demanding careful attention. This is why it is always better to set up as many precautionary measures as possible so that there is a better chance that the family's agitation does not escalate.

The team became defensive rather than, be able to take a step back and be conscious of their own emotions and perceptions when dealing with a difficult family meeting. A popular tactic implemented by defensive people is to get others to try to defend or explain their perspective of the situation, and in doing so, actively try to make you unable to accurately assess a difficult incident. The team should not have showed any major reactions and should have been more organized; and a strategy should have been drafted in order to avoid the possibility of any unwanted defensive situations by implementing a corrective action plan to address the inadequacy in the structure of the clini-

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cal setting and the organization of its intake and treatment, etc. The local attitudes of the staff members and habits should have been taken into account to some extent in explaining the cause of the situation; knowing that perhaps individual team members are more open to suggestions made in private than at the moment, in front of a group. The team should agree with respect to their views on which languages and behaviors should be deemed unacceptable. A pre-established protocol would have been more helpful in avoiding an immediate reaction from the team, it would have helped keep the focus off the treatment team's defensive reaction and the team would have had an organized structured game plan for specific tactics and strategies to move forward.

Administration Alliance

When there is any indication for potential "fallout" from a meeting, the team is best served by pre-empting any calls or letters to supervisors and administrators by informing the appropriate office, such as patient services, in advance regarding the predicted case.

Ethical conflicts are unavoidable in today's healthcare settings; many a times the administration is so far removed from the clinical setting that they are unaware of the challenges that the clinical staff face on a daily basis. The patient may be discharged too early and not receive appropriate care, secondary to the team who would avoid resorting to any daily conflicts with the patient's family. It is important to deal with these ethical conflicts together as a whole, administration and the clinicians, in order to improve patient care and also avoid employee burnout and job turnover.

The hospital is located in one of the wealthiest communities in the country, which also comes with an air of entitlement and narcissism. The members of the community show an attitude which indicates that they are more deserving than others characterized with limited empathy, which poses additional challenges for the team taking care of them.

(PSYCHO) DYNAMIC STRATEGIES

Psychodynamic Formulation

As the adage goes, forewarned is forearmed. The treatment team is best prepared for a family meeting if they have a good understanding of the patient dynamics and can anticipate the family behavior as per the available information. In the discussed case, the father's demanding behavior on the telephone suggested that the parents could possibly get absorbed into the patient's psychopathology. Experience demonstrates that the intellectual exercise of diagnosis and anticipation results in a clinical distance from enmeshment in the family. Intellectualization is a potent defensive mechanism.

A borderline patient who projects her hatred towards the staff by complaining about the way the unit functions may well do the same to the family concerned. Sometimes this takes the form of blaming the family and provoking an intra-familial fight. But sometimes, as in the case here, the patient induces the family to act-out her rage and *vice-versa*.

This understanding necessitates the importance of a comprehensive diagnosis of the patient, not just a DSM diagnosis, but a basic psychodynamic formulation as well. Knowing that in the present day of short lengths of stay, diagnostic depth cannot be readily attained. However, speculation on possible family/group dynamics can be useful and can give the clinician an edge over the situation when dealing with patients and their family members.

Awareness of Psychodynamic Mechanisms

Being aware of the psychodynamic mechanisms is the first step towards defining preventive strategies.

Some of these factors that require attention include projection and projective identification. There are various other categories of mechanisms, patients and combinations of both common to the group therapy literature that will be important to keep in mind such as: "the monopolist", "the HRC" (help rejecting complainer), "the SRM (self-righteous moralist), the "doctor's assistant", or the "silent" patient, just to name a few. Each type has a general prescription for its management.[7]

The need to even be aware that a similar situation has developed and a proper direction is needed is the key especially towards the earliest signs of discomfort, confusion or distress. Several metaphors ("take a step back" or "rise up to the balcony for the proper perspective") come to mind in this respect, but the most compelling one is that of the disoriented diver frantically struggling to get to the surface to no avail, often deepening trouble and mounting panic. The only solution is to consciously be still and observe the direction of the surfacing bubbles for proper reorientation. Likewise, the clinical team members need to understand a situation before any further deterioration has taken place to reassess the dynamics and mechanisms at play. This strategy is indispensible to the team not only to regain control over the meeting and steer it towards a productive end, but also to avoid being a part of the unfolding drama.

Finally, an argument may easily arise that the team would have done the best if they had not played in to the hands of the family by not convening a family meeting at all. This would have avoided a venue and group setting wherein the psychopathologies were most clearly observed. Indeed, the main goal of the paper is to give the reader a perspective of this experience to consider any "upstream" decision as a future direction should they have a similar case.

CONCLUSION

There is a wide range of potential experiences that a clinical team is exposed to when convening a family meeting. Powerful

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emotions may be evoked in both the family as well as the clinical team. Awareness of this is critical in managing the structure and flow of the meeting as well as the potential effects on the patient, the family and the clinical team. Forewarned is forearmed. But awareness alone may not be enough to prevent an experience akin to acute stress-like symptoms shown by the clinical team. Processing sessions after such traumatic family meetings with "potentates" could be a productive learning experience. But most important is a comprehensive checklist of preventive measures that span the full spectrum from concrete to psychodynamic potential sources of "attack". We see this paper as an initial effort for today's inpatient community to develop a manual or guidelines on holding inpatient family meetings. Such a manual is needed by clinicians across multiple disciplines to serve their patients better. There are almost no existing empirical evidences of the value of family meetings in an inpatient setting. Most empirical evidences are centered on the pediatric and geriatric population, in medical settings concerning the ICU, palliative care and oncology.

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