Working with Difficult Patients/Personality Disorders

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Webinar Objectives

- Identify common difficult situations.
- Formulate the behavior(s) to be targeted by the clinician and the team to address difficult clinical situations.
- Develop and apply a systematic approach to working with difficult clinical situations.
- Put the approach into practice with real case examples in a follow-up case call.
Difficult Patients:
How do they make you feel?

Name the emotions you experience when working with your difficult patients.

• ??
• ??
• ??
• ??
Who are the difficult patients?
Who are the difficult patients?

- Help/rejecting patient
- Emotionally dysregulated patient
- Chronically suicidal patients
- The splitting patient (I hate my doctor, they hate me; the stories don’t match)
- The non-engaged patient:
  - the disappearing patient, who only comes in crisis
  - the patient who won’t talk
  - the patient who always agrees, but never follows through
  - the patient who wants something you can’t offer (i.e., more medication, housing, “a quick cure”)
What gets in the way?

Judgmental Statements

- “manipulative”
- “med seeking”
- “not doing anything”
- “not willing to do anything”
- “doesn’t want treatment”
- “angry at me for no reason”
- “annoying” or “demanding”
How can we be more effective?

Focus on behaviors

Why?

• To help us **focus** on treatment: create a **target** for intervention
• To align us with the patient – promotes **patient centric care**
• To solve the problem(s) **faster**
Understanding Consequences

Patient Problematic Behavior: *erratic attendance and always in crisis...*
Target: *come in more consistently and not always in crisis*

**Increase Behavior**

**WORKS!**

**Negative reinforcement**
- take away something bad
  - Example - brief, minimal interaction for the chronic crisis clinic presentation

**Positive reinforcement**
- adding something good
  - Example - long, thorough, warm, empathic interaction for the non-crisis clinic presentation

**Punishment**
- adding something bad
  - Example - judgmental and critical reaction

**Decrease Behavior**

**DOESN’T WORK**
5 Steps for Success!

1. Name the **emotions** the patient is evoking in you.
2. Define patient’s **problematic behavior** in functional terms.
3. Identify your and your team’s **treatment interfering behaviors**.
4. Develop a **team-based behavioral approach** to working with this patient. (use reinforcement!)
5. Address your needs for **support** in working with this patient (consultation, consistency, self care).
Take care of yourself!

Addressing Needs for Support:

<table>
<thead>
<tr>
<th>Do <strong>good self care</strong> for the emotional distress from your job (and life).</th>
<th>Acknowledge your own and the system’s limitations – what you can and can’t affect; <strong>validate your efforts</strong></th>
<th><strong>Seek team / peer support</strong> (don’t “go it alone”)</th>
<th>Get good <strong>consultation</strong> if needed</th>
</tr>
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</table>
Case Example

50 year-old Caucasian woman, Major Depressive Disorder, chronic pain, Pain Disorder with high anxiety and depression, ADHD – tx is focused on a Suboxone taper and mental health (depression and pain self management)
5 Steps for Success

1. Emotions: frustration, anger, blame

2. Patient’s problematic behavior: Help / rejecting – constantly late leaving less than ½ the appointment time, always comes in distressed initially

3. Team’s interfering behaviors: reinforce her late behavior by - allowing her to go over her allotted time, rescheduling her at last minute, staying late for her

4. Team based approach (MD, PA, nurse CC, PhD, MD psych): no longer seen in the same day if more than 10 minutes late, do not go over allotted time, keep interactions during business hours, reinforce her each time she’s seen and encourage her ability to succeed

5. Support: reinforce each other for sticking to the plan, monitor her behavior together, validate our success at keeping boundaries
# Strategies for some typical difficult patients...

<table>
<thead>
<tr>
<th>Patient Presentation</th>
<th>Behavioral Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help / rejecting patient</td>
<td>• Validate</td>
</tr>
<tr>
<td><em>Comes in late to appointments; asks for help then gets angry at providers</em></td>
<td>• Be consistent</td>
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<tr>
<td></td>
<td>• Practice good boundaries</td>
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<td></td>
<td>• Promote use of skills</td>
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Strategies for some typical difficult patients...

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<tr>
<td>Emotionally dysregulated patient</td>
<td>• De-escalation</td>
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<td>Calling frequently and frantically; Crying entire session without being able to be redirected; Overstays sessions</td>
<td>• Ground them</td>
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<td></td>
<td>• Triage (safety planning, problem solve, crisis manage)</td>
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<td>• Assess their current use of skills</td>
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<td>• Move to treatment – either problem solving or use distress tolerance/crisis management skills</td>
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| **Chronically suicidal patients**  
*Every other visit patient presents with active SI; Regularly threatens to harm self* | • Triage (safety planning, problem solve, crisis manage)  
• Assess their current use of skills  
• Move to treatment – either problem solving or use distress tolerance/crisis management skills |
## Strategies for some typical difficult patients...

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| **The splitting patient (I hate my doctor, they hate me; the stories don’t match)** | • Validate patient’s perspective  
• Support and problem solve engagement with treating providers  
• Promote use of skills in working treatment team |

*Spends the whole session complaining about PCP; PCP has a different story than what the patient says*
The non-engaged patient...

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<td><strong>The disappearing patient, who only comes in crisis</strong></td>
<td>• Triage (safety planning, problem solve, crisis manage)</td>
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<td><em>Presents in crisis, then no shows for several visits, then re-presents in crisis</em></td>
<td>• Assess their current use of skills</td>
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<td>• Move to treatment – either problem solving or use distress tolerance/crisis management skills</td>
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<tr>
<td></td>
<td>• Create consistent schedule and consolidate care with treating providers</td>
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<td>• Reinforce any non-crisis driven interactions</td>
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<td>The patient who won’t talk</td>
<td>• Focus solely on engagement (defer treatment)</td>
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<tr>
<td>Silent; Provider generates all ideas/goals</td>
<td>• Try to identify motivations for coming in and THEIR treatment goals (not your own) – ask “If our time was spent well, how would you know?”</td>
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<td><strong>The patient who always agrees, but never follows through</strong></td>
<td>• Do more assessment to understand function of “agreeing” behavior</td>
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<td><em>Does not complete homework; Makes many “great” excuses; Says “likes” the idea but does not follow through</em></td>
<td>✓ Is it a trust issue and lack of engagement (i.e., pushing for treatment before you have good credibility)?</td>
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<td>✓ Is it a cultural issue (i.e., agreeing out of respect)?</td>
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<td>✓ Is it a goal issue (i.e., the goal is too overwhelming or the goal is not aligned well with the patient’s goals)?</td>
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<td>✓ Is it a lack of understanding or lack of skill</td>
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The non-engaged patient...

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| The patient who wants something you can’t offer (i.e., more medications, housing solutions/resources, “a quick cure”) | • Do more assessment to understand function of the request  
✓ Is it a problem you can actually address?  
✓ Do they have distress tolerance skills to handle having a problem they can’t solve?  
• Focus on engagement  
• Better align treatment with patient goals |
| Makes many demands or voices high expectations (housing fix, time, medications) | 
Questions
Cases

1. Emotions

2. Patient’s problematic behavior:

3. Team’s interfering behaviors

4. Team based approach (MD, PA, nurse CC, PhD, MD psych)

5. Support
Ms. G is a 45 year old unemployed Dominican Spanish speaking female, domiciled in the Bronx with her sons aged 11, 17, & 24, financially supported by public assistance. Pt carries diagnoses of chronic headaches, asthma, obesity, anxiety, and depression and was referred to the DCM by her PCP at the Washington Heights clinic in the context of worsening depression and falling out of treatment at her MH clinic in the Bronx (2012-2014). Ms. G has no history of SI, denies substance use/abuse. Ms. G’s life stressors include: financial stressors; health issues; loneliness/isolation; and interpersonal difficulties with children (17 y.o. diagnosed with SPMI and refuses treatment). DCM tried to refer pt out as per psychiatry consultant’s recommendation however pt did not follow through with MH referrals. Pt’s depression is currently being managed by PCP who is prescribing antidepressants. Pt has engaged with behavioral activation and initial PST sessions with DCM, but continuously misses appts and refuses phone contacts as she has a pay-as-you go phone with limited minutes.