WORKING WITH PERSONALITY DISORDERED AND CHALLENGING PATIENTS:

Understanding and Managing Such Encounters

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Learning Objectives

1

Learn about factors that influence a patient's presentation as "challenging" or "difficult"

2

Learn about factors for ourselves as healthcare providers that can contribute to experiencing such patients as "challenging"

3

Develop approaches that minimize the impact of such factors and optimize the effectiveness of the provider-patient relationship

Disclosures

None

Why managing "challenging" patient encounters is important

15% of patients in primary care settings are viewed as "challenging". Yet, independent of physical illness or demographics, compared to "non-difficult" patients, they

- Are among the highest utilizers of healthcare services
- Express higher dissatisfaction with care
- Experience greater functional impairment

(e.g., Hahn, et al., 1996, 2001; Tamura, et al., 2022)

The Difficult Doctor-Patient Relationship Questionaire-10 (DDPRQ-10)

A 10-item questionnaire completed by the healthcare provider post-encounter that has revealed general factors, or some combination thereof, that characterize patients as “difficult”

(Hahn, et al., 1994, 2001)

3 FACTORS THAT CHARACTERIZE "CHALLENGING" PATIENTS

1. Presentation of vague or multiple somatic complaints
2. Presence of a personality disorder
3. Presence of "mental illness" such as depression or anxiety

(e.g., Hahn, 2001; McPherson, et al., 2014;; Tamura, et al., 2022)

1. Presentation of Vague/Multiple Somatic Complaints

Presentation of Vague/Multiple Somatic Complaints

- The number of physical symptoms AND somatoform complaints correlates with degree of patient's "difficulty" level—even in anticipation of seeing patient

- Any 1 of 5 particular symptoms correlates with "difficulty" level:
  - Stomach pain
  - Fainting
  - Diarrhea/loose stools
  - Palpitations
  - Sleep problems

(Hahn, 2001; Jackson, et, al., 2020)

Understanding Somatizing Patients

Lack of support during development for transitioning from a sensory-motor way of experiencing and communicating, to a verbally mediated, representational level of experiencing and expressing oneself

Example of Childhood Tantrum: Physical (sensory-motor) in Nature

Helpful Parenting Response: Attentive, Attuned, Labelling, Explanatory

Additional "Difficulty" Factors

On the Patient's Part:

- Unmet expectations
- Lower satisfaction with care
- Demandingness in aversive manner

On the Provider's Part:

- Desire/need to problem-solve
- Desire/need to be the helpful provider
- Wish to avoid unpleasantness

Suggested Ways of Interacting

- Empathically listen and reflect
- Make your intent to understand **explicit**

Example:

"So, let me see if I've heard you correctly…"

"Is that right?"

"Is there anything else about this that you think I should know?"

The Power of Empathy

- Calming, emotionally stabilizing impact
- Bi-directional enhancement of the relationship
- Subsequent facilitation of intervention effects
- Decrease in ratings of patient as “difficult”

(e.g., Leaviss, et al., 2020; Tamura, et al., 2022)

2. Presence of a Personality Disorder

Presence of Borderline Personality Disorder (BPD) in Particular

BPD in Primary Care Setting

- 12 - 19% prevalence: 4 times greater than general population
- Half of PCP patients' BPD goes undiagnosed or under-treated
- More medical comorbidities AND higher utilization of medical services
- 30% of patients with chronic pain disorders diagnosed with BPD
- BPD pts with a history of trauma more likely to present with somatic complaints

(e.g., Sansone, et al., 2011; Wu, et al., 2022)

Borderline Personality Disorder (BPD)

Pervasive pattern of instability in interpersonal relationships, self-image and affects, with marked impulsivity, beginning in early adulthood and present in a variety of contexts, as indicated by 5 or more of the following:

Diagnostic criteria for BPD (DSM-5):

- Frantic efforts to avoid real or imagined abandonment
- Unstable interpersonal relationships (idealizing vs. devaluing)
- Unstable self-image or sense of self
- Impulsivity that is potentially self-damaging
- Recurrent suicidal behavior/self-mutilating behavior
- Affective instability due to reactivity of mood
- Chronic feelings of emptiness
- Inappropriate intense anger
- Transient stress-related paranoia or dissociative symptoms

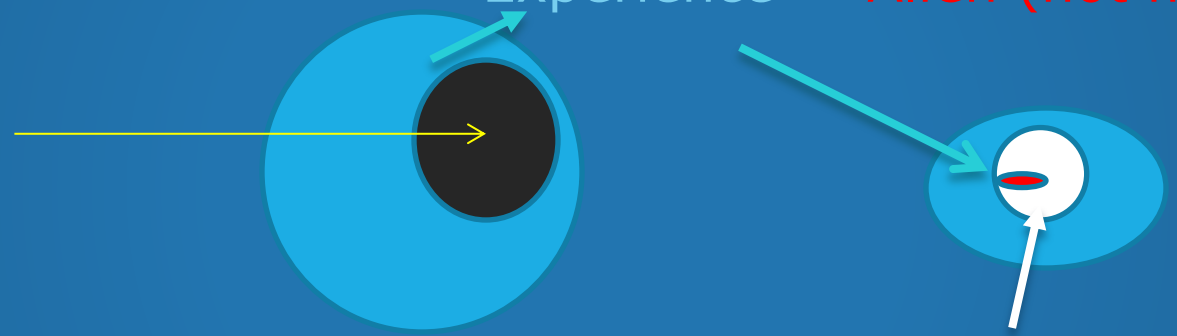
Understanding BPD

The lack of a secure attachment to an early parental figure, and inadequate emotional support during early development, result in the later, adult BPD patient who has difficulty with emotion-regulation, interpersonal stability, and stress tolerance.

The Early Caregiver's Inadequate Response to the Child

Absence of a representation of the child's experience

Caregiver's Experience--> Alien (not me) self



Caregiver-Attachment Figure

The child's nascent self

The child takes in what the caregiver responds with--an "alien" experience--instead of a reflection of the child's authentic experience.

(adapted from Fonagy & Bateman, 2016)

Splitting and Triangulation

Patient emotions

"Good" feeling

"Bad" feeling

Preserve the good by splitting off the bad

Provider Factors Evoked by Challenging/BPD Patients

- Subjective need to try to meet patient demands, in part …
- In the context of our professional role and identity, and
- Reinforced by our training
- Perhaps as part of our positive image of ourselves, not only as professionals but as good, admirable people, OR
- Out of frustration, simply to put an end to the patient's demandingness

Managing Our Reactions to Patients with BPD

- Monitor ourselves for a possible **atypical** reaction
- Remind ourselves such reactions are **transient**
- Take a moment to regain our equilibrium
- Attempt to be empathic
- Resume/reinstate the structure of the treatment

Not feeling like yourself??

Mental Time Out

Take a “mental time out”: a moment to recognize what’s happening, take a deep breath, and regain your equilibrium as the provider

3. PRESENCE OF MENTAL ILLNESS SUCH AS DEPRESSION OR ANXIETY

"Major" Mental Illness:
e.g., Major Depressive Disorder (MDD);
Generalized Anxiety Disorder (GAD):

"Difficult" patients have been found to be more likely to have a diagnosable mental disorder such as MDD or GAD (approx. 65% of "difficult" patients, vs. 35% of patients not rated as difficult)

(e.g., Jackson & Kroenke, 2001)

The Depressed Patient

Chronically depressed patients often:

- Express hopelessness
- Have difficulty focusing on reality-based options
- Wish for the impossible as an alternative
- When that fails, experience suicidal ideation as a solution

Provider Reactions to the Depressed/Suicidal Patient

- Feeling hopeless in a parallel way
- Feeling “de-skilled”
- Trying to do the impossible along with the patient
- Conversely, becoming dismissive and/or curtailing contact

Managing Reactions to Depressed Patients and SI

- Reminding ourselves our own reactions are **transient**
- Providing the experience of someone wanting to listen—empathy again!
- Listening for why patient is feeling suicidal and hopeless **at that particular point in time**
- Listening for an opening to focus on--with the patient--that can be helpful

Add'l Provider Factors Influencing Reactions to Patient Encounters

Negative Impact

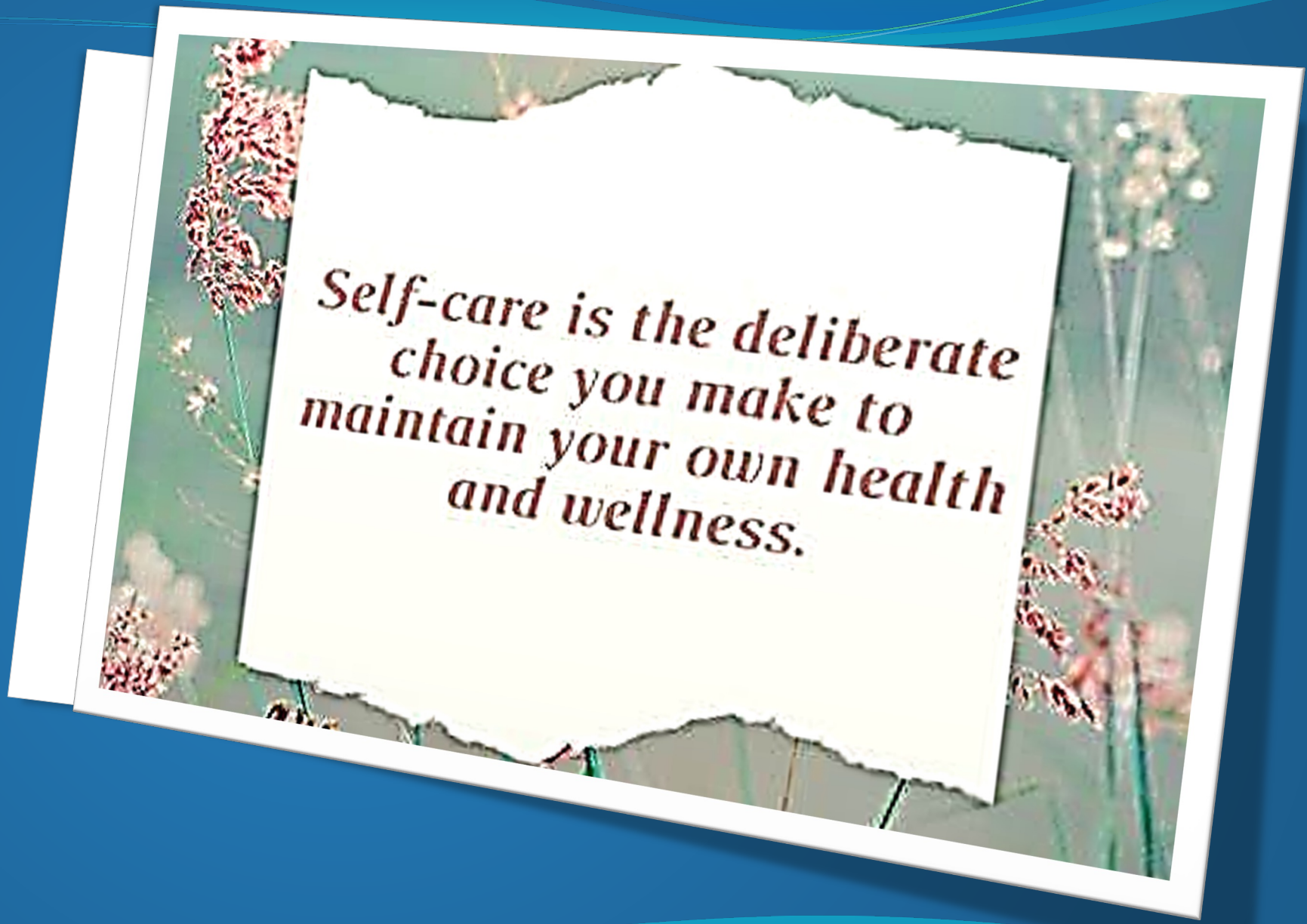
- Lack of confidence/experience working with patients with poor communication skills and psychiatric problems
- Looking to one's work for a degree of satisfaction exclusive of other areas of life
- Impact of the demands of work

Positive Impact

- More years of experience as a provider lead to viewing patients as **less** "challenging"
- Greater empathy toward patients results in viewing fewer patients as "difficult"

(e.g., Tamura, et al., 2022)

Thank you for attending this session and considering these thoughts about working with challenging patient encounters!!



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