

DIFFICULT PATIENTS AND DIFFICULT DOCTORS

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AIMS

- Illustrative case
- Challenging patients
 - pain
 - attachment
 - ACEs and the position of victim
 - personality
- What are we really like?
 - medical selection
 - how we respond
- The mix

Case

- 24 yr old woman
- 2 years of recurrent admissions to GI
- Abdominal pain
- Initially RUQ
- Increasingly generalised
- Longest time at home 5 days in past 11 months
- Unwell 4 years

- 1 year history of resistant asthma
- Low mood
- Progressed to a picture of malaise, fatigue and abdo pain

Case

- 3 yr history of Churg-Strauss – ‘relapses’

- Previously outgoing
- Volunteer and carer
- Parents separated
- Father lives in Spain
- Seems better when with him

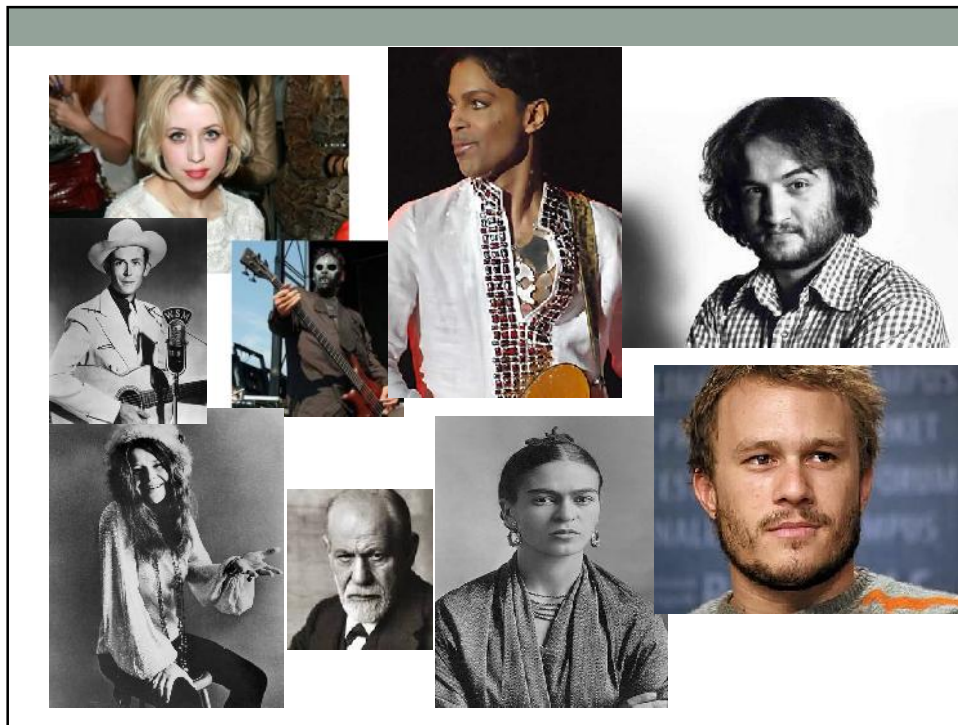
Case

- Diligent Rheumatologist
- Close and careful follow up
- Tertiary referral

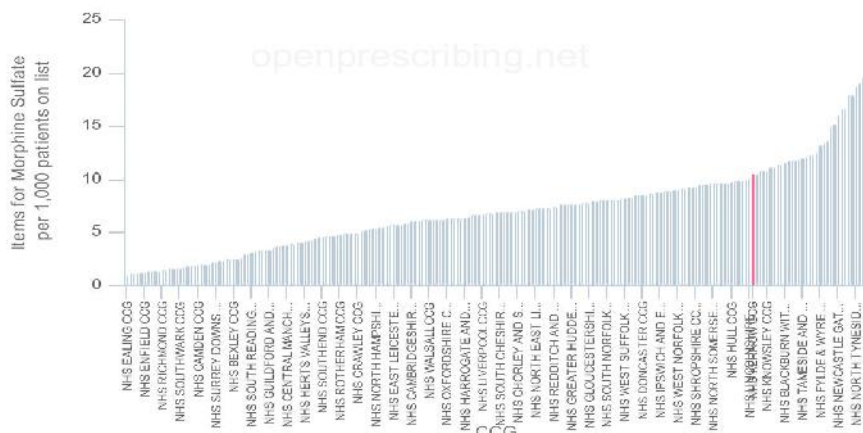
- Gastro ward – consultant change every 2/52
- Nurses unhappy with care
- Very attentive to pain timings
- 600 - 700mg OME per day

- Fentanyl patch, iv morphine oramorph, MST

MEDICATION



Items for Morphine Sulfate vs patients on list by NHS KERNOW CCG



DEPENDENCE AND ADDICTION

Dependence Syndrome ICD10

Three or more during the previous year

- Strong desire or compulsion
- Difficulty controlling use – onset, termination, levels
- Withdrawal state (or use of drugs to avoid)
- Tolerance – higher amounts for same effect
- Neglect of alternative pleasures or interests
- Persistence despite use despite harm

Also – narrowing of repertoire / may only become aware of compulsion when withdrawn

ASAM — American Society of Addiction Medicine

- In cortical, hippocampal circuits and brain reward structures previous exposures to rewards leads to biological and behavioural response to external cues
- Neurotransmission within reward structures nucleus accumbens, anterior cingulate cortex, basal forebrain and amygdala
- Motivational hierarchies are altered
- Addictive behaviour supplants healthy, self-care related behaviour

ASAM – not only reward

- Altered connectivity in frontal cortex and between reward, motivation and memory circuits manifests in altered:
 - impulse control
 - judgment
 - dysfunctional pursuit of rewards
- Frontal lobes are important in inhibiting impulsivity and in assisting individuals to appropriately *delay gratification*

ASAM – other factors

- Disturbed social support systems and inter-personal relationships has an impact on resilience
- Disruption in meaning, purpose and values
- Previous exposure to trauma
- Presence of psychiatric illness

- Cognitive and affective distortions

Cognitive Factors

- Preoccupation with substance use
- Altered evaluations of the relative benefits and detriments associated with drugs or rewarding behaviour
e.g. 'I would never try that
- Inaccurate belief that problems experienced in one's life are attributable to other causes rather than being a predictable consequence of addiction

Emotional Factors

- Increased anxiety, dysphoria and emotional pain;
- Sensitivity to stressors associated with the recruitment of brain stress systems
- Difficulty in identifying feelings, distinguishing between feelings and the bodily sensations of emotional arousal, and ascribing feelings to other people (alexithymia)
- Tolerance to 'highs' but not to 'lows'

Opiate Seeking Behaviour

- Pt 'But I'm not an addict...'
- Dr '...then don't behave like one'

Clock watching for timing of medications
 Request for narcotic, benzodiazepine, or muscle relaxant medication by name
 Requesting a refill of narcotic, benzodiazepine, or muscle relaxant medication
 Reporting that narcotic, benzodiazepine, or muscle relaxant medication had been lost or stolen
 Reporting ten-out-of-ten pain
 Reporting greater than ten-out-of-ten pain
 Reporting being out of narcotic, benzodiazepine, or muscle relaxant medication
 Requesting medication parenterally
 Discontent from staff - splitting

OTHER COMPLICATED PATIENTS

Attachment – Bowlby 1958

- Repeated interactions between the infant and care giver prompt the infant to develop models of both seeking and receiving care from those on who they depend.
- These models or 'attachment styles' tend to persist, they influence expectations particularly from those on whom we depend
- Family, romantic partners
- And doctors

Attachment

- SECURE ATTACHMENT
- Recall consistently reliable care-giving. Positive view of self and others. Comfortable depending
- DISMISSING ATTACHMENT
- Unresponsive caregivers. Need to see themselves as self sufficient. Others cannot be relied upon
- PREOCCUPIED ATTACHMENT
- Inconsistently responsive care-givers. Image of self as unlovable and others as able, but not always willing to support. Never sure, so can be vigilant but clingy
- FEARFUL ATTACHMENT
- Rejecting experiences of care. Negative image of self and others. Long for closeness, but fear rejection. Vacillate between approach and avoidance

Abusive experiences

- Schilte 2001 Scan J Primary Care – 200 patients with MUS in General Practice - 4/5 adverse childhood experiences
- Weurlel et al 1990 Clin J Pain – 135 chronic pain patients 28% reported CSA 39% of women and 7% of men
- Drossman et al 1990 Annals Int Med – patients with functional GI disorders – 44% sexual or physical abuse (1/3 never told anyone, 17% had told doctor, more multiple symptoms, higher rates of surgery)
- McCauley et al 1995 Annals Int Med – 2000 women in primary care – 1 in 20 DV in past year, 1 in 5 as an adult, 1 in 3 as child or adult (increased substance abuse, total symptoms, ED attendance)

What is really going on?

- COGNITIVE ANALYTIC THEORY
- We tend to respond to people in the way we anticipate they will treat us
and
From how others relate to us, we learn how to relate to ourselves.
- Personal biographical history
- Reciprocal roles
- Abuse and Neglect

What is really going on?



Mother
Caring
Valuing

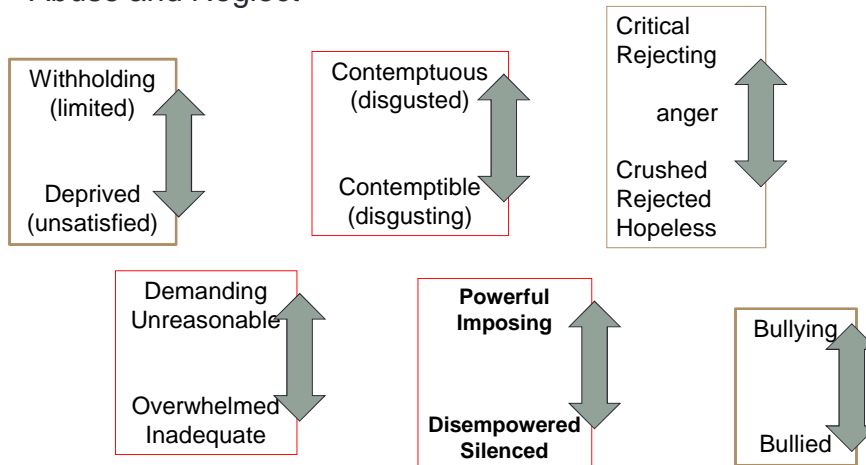
Child
Cared for
Valued

Child/Self
Caring
Valuing

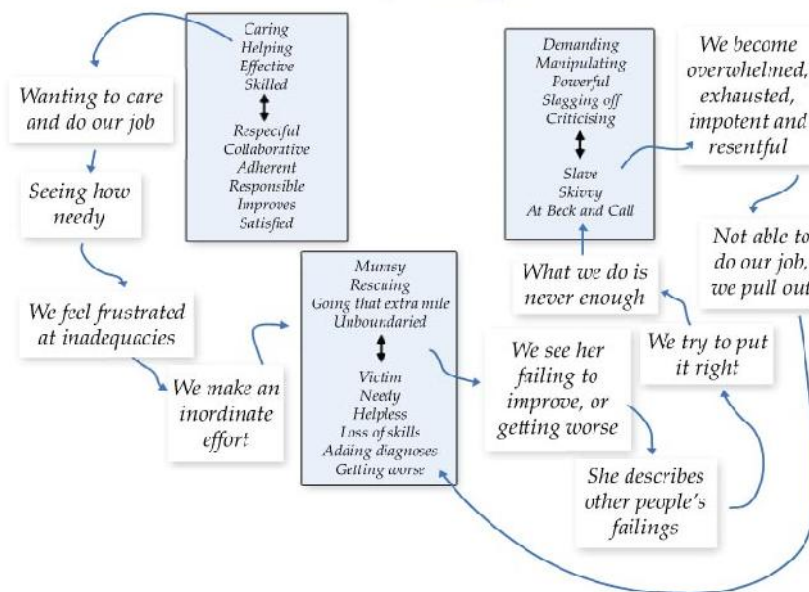
Child/Self
Cared for
Valued

What is really going on?

- Abuse and Neglect



When offering less gives more



PERSONALITY DISORDER

Personality Disorder

- Our personality is the way we think and feel and behave. Some people think and feel and behave in ways that make it very difficult for them to get on with other people and cope with ordinary life. They may have difficulty controlling their feelings and behaviour and may get very angry and distressed and hurt themselves or other people. These people are often diagnosed with a personality disorder.
- Marked deviation in enduring patterns of inner experience and behaviour:
 - cognition
 - affectivity
 - impulse control
 - inter-personal relationships

- Pervasive inflexible and maladaptive in a broad range of situations
- Personal distress or social dysfunction
- Since early adulthood
- Not related to a mental illness or brain disease

Personality

- From 'persona': the mask
- The interface between our individual experience and the social world

Two main functions:

- (1) internal regulation of negative arousal and affect
- (2) Caregiving and care-eliciting relationships with peers and in kinships

Personality Disorders

- Anti-social
- **Emotionally unstable / borderline**
- Histrionic
- **Anankastic / obsessional**
- **Dependent**
- Anxious / avoidant
- Schizoid

- Narcissistic

Personality Disorder – Prevalence

- UK Community:
4% (but <1% severe: Yang et al 2010)
- Primary care:
10% (mainly affect dysregulation and somatisation)
- Secondary mental health care:
33%-60%
- Prisons/Forensic services:
70%

PD in General Practice

- Psychol Med. 2001. ***The impact of personality disorder in UK primary care: a 1-year follow-up of attenders.*** Moran P, et al.

BACKGROUND

- The usefulness of the concept of PD has not been properly tested outside psychiatric services.

METHOD

- 1 year follow up of previously assessed cohort (303pts 24%)

RESULTS

- Rating of PD (psych) associated with frequent attendance to GP and fewer referrals to secondary care.
- Level of agreement between ratings – poor
- *GP rating of PD associated with prescribing psychotropics*
- GP rating - less compliant, less likeable and more stressful to deal with
- *Psych rating of PD – did not attract negative perceptions*

Common Experiences

- Insecure Attachment
- Fear of abandonment
- Intense unstable relationships
- Splitting – *crying baby story*
- ‘manipulation’ – *not very good at it*
- Intense frustration and anger
- Mood swings
- Chronic emptiness / boredom
- Identity disturbance
- Self harm

Splitting and Manipulation

- What is splitting?

Is manipulative an accurate description?

Karpman Drama Triangle



Transactional Analysis

DIFFICULTIES

- Flexibility
- Intensity
- Tenacity

SOLUTIONS

- Creator
- Challenger
- Coach

COMPLICATED DOCTORS

Desirable Characteristics of Healthcare Professionals

- Organised
- Physically strong
- Compassionate
- Enthusiastic
- Empathic
- Patient
- Problem solving
- Creative
- Dedicated
- Flexible
- Helpful
- Good communicator
- Outstanding interpersonal skills

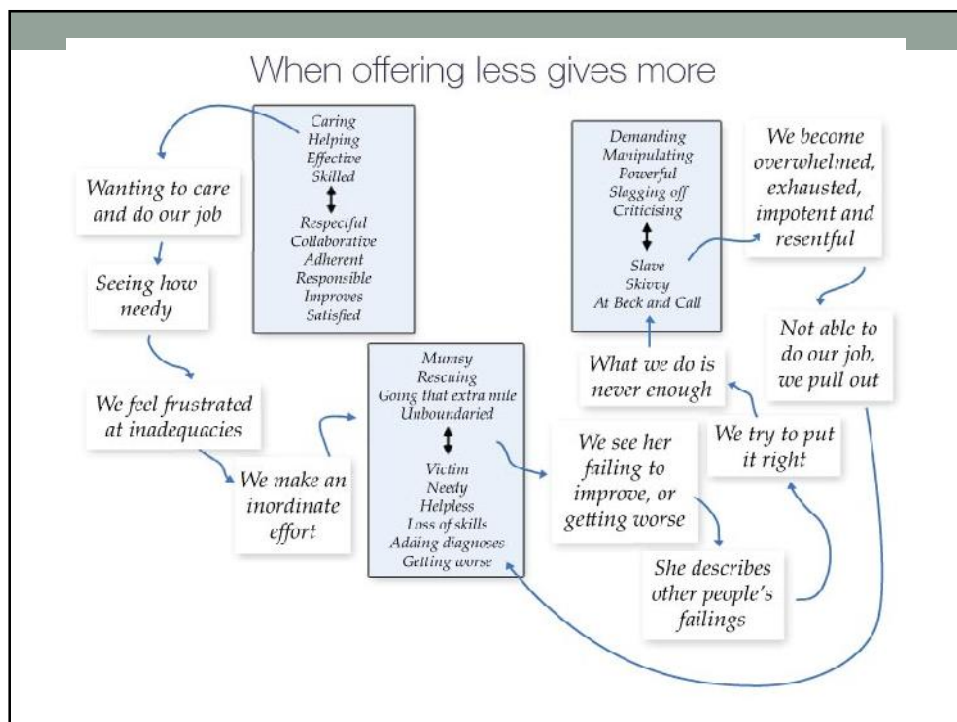


"I'm considered a saint, but my mother always thought I could've done better."

Selection

- Doctors are highly selected group
- External selection: intelligence, social function, altruism, conformity, consistency
- Self selection: conscious altruism, social care and authority, high achievers,
- Unconscious: compulsive care giving, perfectionism, compulsiveness, self-criticism, being appreciated, unresolved experiences of loss or illness

- Medicine selects *against* many negative personality dimensions/traits **And** selects *for* positive resilience and traits
- Doubt, guilt,
- Compulsively responsible
- Studies in different specialities find slightly different profiles
- Conscientiousness predicts success
- Those high in neuroticism struggle later



Personality Disorder in Doctors

- A slight excess of PD in medical students
- 2% in physicians, 9% in anaesthetists!
- Doctors referred for SBV: show antisocial personality traits
- Addiction services: 59% of addicted doctors
- In one study, 24% psychiatrists score highly on a psychopathy scale!

Does the medical/health culture support and select for these beliefs?

- Narcissism: I am the greatest
- Perfectionism: I must do this right and mistakes are intolerable in me/others
- Compulsiveness: I have to do this, and I can't give up till I finish
- Denigration of vulnerability: People who need help are failures
- Shame: if I am in need, I am a failure
- Self-protection: loss of motivation, commitment
- Openness: resilience? emotional incontinence,

What is your work like?

- Regular dealing with trauma / loss events
- Dealing with other people's distress
- May acquire new care-giving responsibilities **outside** work just as they become most responsible **at** work
- Selected for traits that increase vulnerability if stress is long-term: perfectionism, compulsiveness
- Effect of resilience factors: intelligence, warmth, talents, mature defences, attachments?

- Strengths may become weaknesses
- Co-morbid depression exacerbates negative traits
- Group dynamics / management changes

CONCLUSIONS

Case

- Agreed gradual opiate reduction
- Went faster than expected
- Off all opiates
- Pain – almost entirely gone

- Gratitude

Conclusions

- Addiction is important
- Be aware of the frequent presence of abusive experiences in people's biography and its impact
- The victim triad
- Notice if you are dancing
- Teamwork
- Be open, talk to your colleagues
- Change your mind – Belief Superiority / Intellectual Humility

- Notice yourself and look after yourself
- Look after each other
- THANK YOU

- BELIEF SUPERIORITY
- Hall and Raimi, 2018. Is belief superiority justified by superior knowledge? *Journal of Experimental Social Psychology*
- Political / environmental

- INTELLECTUAL HUMILITY
- 67% right more than others
- Some have low IH. Pay less attention to evidence, less often double-check. Associated with derogatory views of others.
- Assortative mating. Men's associated with discontent