UW ECHO in Geriatrics

8/18/2022 | Communicating with Difficult Patients| Dr. Pignatore, Dr. Borson

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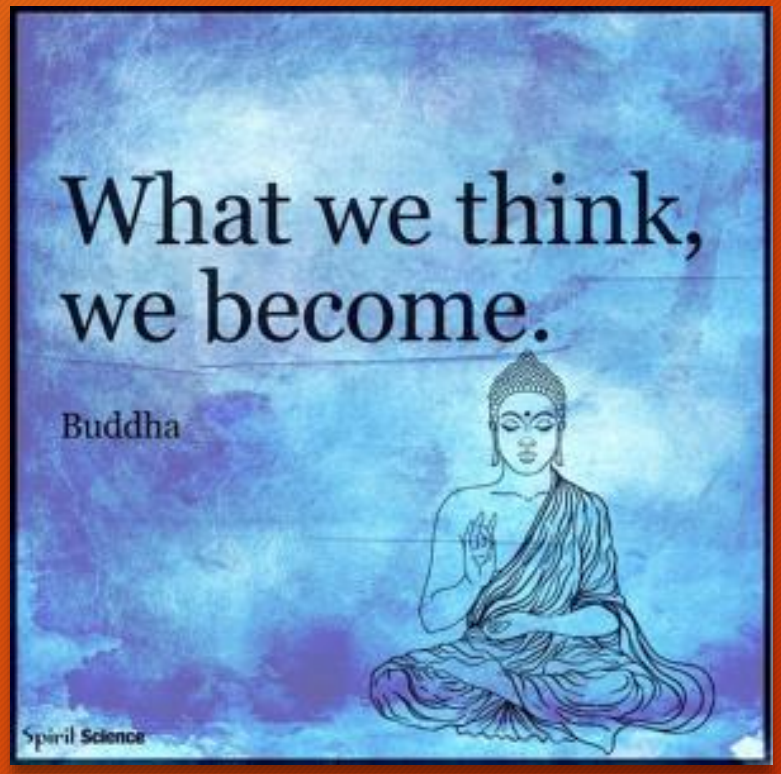
OBJECTIVES

- Help medical staff better understand and empathize clients with challenging behaviors.
- Identify common staff reactions to challenging behaviors.
- Identify 3 skills for responding to challenging behaviors.


What we think,
we become.
Buddha
Spiril Science

Understanding Difficult Behavior

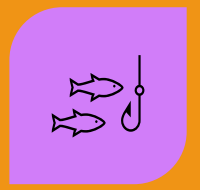
- What are we talking about? Behavior that *seems to be under the person's control* – but gets in the way of a personal or helping relationship.
- A *pattern* of behavior – not a one-time thing. Examples:
  - Intentional poor hygiene
  - Messy/dirty/dangerously cluttered home
  - Not taking important medications
  - Not following important medical recommendations
  - Expressing unwarranted anger toward staff or others -e.g. 'throwing a fit', profanity, storming off
  - Rude or inappropriate behavior
- Our own reactions to the person can be clues to what's going on.

Our Emotional Reactions Are Often Clues

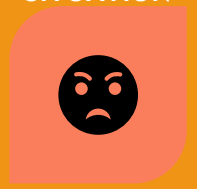
SURPRISED, CONFUSED, OFF-BALANCE - THE BEHAVIOR WOULDN'T BE EXPECTED IN THE SITUATION

FEELING MANIPULATED

THINKING S/HE'S 'JUST DOING IT TO UPSET ME'



GETTING 'HOOKED' - 'PEOPLE WHO ACT THIS WAY ALWAYS MAKE ME FEEL…'



FEELING ANGRY

FEELING 'USED'

DISLIKE

PITY

What would you call behavior that elicits these kinds of reactions?

Clinically, We Might Call Them “Personality Disorders”

- Personality disorders are enduring patterns of behavior that appear maladaptive to others.
- These patterns often develop early in life as a way of coping with an overwhelming or stressful environment.
  - Lying- a way to avoid physical or verbal abuse, shame, rejection
  - Hostility/Blaming Others- re-enactment of behaviors observed in childhood; avoidance of shame or guilt
  - Manipulation- attempt to gain control in a situation that feels out of control. History of not being able to get needs met through direct requests. History of neglect.
  - Narcissism, self,centered behavior- apparently inflated self-regard; attempts to hide insecurities, fear, avoid being shamed.
  - Paranoia- chronic difficulty trusting others d/t a history of being let down and severely hurt by attachment figures.
  - Shutting Down/Dissociation/Avoidance- ‘turning off’ when faced with a situation one can’t cope with any other way.

Understanding “Personality Disorders”

- The concept of “personality disorder” is used to describe people with patterns of behavior that upset others and often appear maladaptive to the outside observer.
- 80% of people with personality disorder report adverse events during childhood. (Hong, Lishner, & Liard, 2011)
  - 91% of people with Borderline Personality Disorder report childhood abuse. (Zanarini et al, 1998)
  - 92% of people with BPD report childhood neglect. (Zanarini et al, 1998)
  - Estimated that 75% of people with BPD experienced childhood sexual abuse. (borderline-personality-disorder.com)
- Poor attachment relationships in early life are theorized as creating or at least contributing to the symptoms we see as personality disorders. Secure loving relationships with parental figures are necessary for babies and young children’s brain and social development. A severe mismatch between the needs of a child and abilities of a caregiver could lead to problems in brain development.
- But beware ‘blaming the parents’ – some individuals are predisposed; even good parenting can’t always guarantee normal personality development (need more research)

Person Centered vs Clinical Language

- "…person-centered language emphasizes that people are experts in their own lives, health, and needs"
- Clinical/medical diagnoses and terms are 'shorthand' in communicating with other health providers and planning treatment, but can interfere with seeing individuals as whole people.
- Only use diagnoses when necessary. Consider using language to describe other aspects of the person's life, personality and interests.
  - XXX is a 75 year-old who lives alone, uses a wheelchair, and is non-compliant with medications.
  - XXX is a Vietnam Army Veteran who lives with his dog Pepe. He values remaining in his home and being a caregiver to local wildlife. He also has…XYZ medical conditions.
- Use strength-based language. "Mr. X pays his nephew to help him and has a health home aide." Vs. "Mr. X is a total assist for housework."
- Use descriptive language of problems, rather than labels. "Mr. X prefers to take medications based on his own schedule." "Mr. X is medication noncompliant."

Trauma-Informed, Person-Centered Care

- Mr. X is non-compliant with his medications.
  - Mr. X is used to taking his medications a certain way and has difficulty adjusting to new medications/regimens. He has difficulty trusting others and does not trust his new RN to fill his med planners. We will work to build rapport with him slowly, make sure we hear and respond to his questions and misgivings – sometimes many times - and explain at every session what his medications are for and why they have changed. In the future, we hope he might let the RN fill his med planners.
- Mr. X is stubborn and refuses to let home aides in.
  - Mr. X is very firm about his boundaries for his personal space. He feels anxious when people come in and try to move things even if they're just tidying up. He has a history of people stealing from him. We'll work to discuss the pros and cons of home aides with him. We might generate a list of the things he will allow a home aide to do. He might need to meet the home aide a few times before he feels comfortable. We might also ask him about what cues he uses to decide whether to trust someone.

Tools to Use with Challenging People

- Motivational Interviewing- help the client feel heard and understood. Make sure that you understand the clients' perspective and goals. Step back from the "righting reflex." Make connection and understanding your goal.

- Shared goal setting- work with person to identify goals that can be agreed upon.

- Boundaries- maintain professional boundaries and inform the person of where they are when you need to. You set the tone!
  - "I really want to hear about this situation. It's hard for me to listen when you yell/curse. I need you to use polite language. Otherwise, I can come and talk to you another time."
  - "It doesn't seem like we're communicating well today. Would you like me to leave and come back a different day?"

Case Example

- 79-year-old, divorced, Caucasian, male client who lives alone. Client is an avid bicycler and used to enjoy glass blowing as a hobby. He takes pride in being well read. Though his income is low, he makes an effort to decorate his apartment with art and present himself as a scholar. Client is estranged from his biological child and has no known family connections or friends.
- He is referred to HBPC with diagnoses of CAD, HTN, multiple cardiac stents, esophageal stricture, GERD, PTSD, personality disorder, hx of prosthetic right eye secondary to trauma. Client lost his right eye due to a fall in his kitchen. Client has weight loss of over 50 lbs. in the past year. Reports that food gets stuck in his throat, resulting in frequent nausea and vomiting. Client has frequent falls due to orthostatic hypotension.
- Client has extensive past psychiatric history with reported past “Cluster B” personality traits and substance abuse. Team suspects that client continues to use marijuana though he denies this.
- Team members observe evidence of altered mental status at one visit and facilitate transfer to the ER. No stroke evident. Client treated for dehydration at ER.
- HBPC team develops concern that client is possibly making himself ill due to mental health problems.

Case Example

- Cognitive Assessment-
  - Blessed Orientation Memory Concentration: 8- does not suggest dementia, but below expectations
  - Baseline Cognitive Skills- Average to High Average
  - Impairments in Executive Functioning skills (Oral Trails A, Control of Information, Abstract Reasoning)
- Review of medical record- past infarcts in left periventricular white matter, left basal ganglia, left putamen; Mild brain parenchymal volume loss. Mild chronic microangiopathic change in the white matter and pons.
- Diagnosis: Mild Vascular Neurocognitive Disorder; Paranoid Personality Disorder.
- New medical diagnosis added - “tortuous esophagus” by GI – likely explains trouble with swallowing/regurgitation; management stabilized his weight.

Take Aways from Case Example

- A person with a personality disorder might present symptoms in an overly dramatic or unusual way.
- This does not mean the complaint is not valid or that the symptoms are "psychological" and not caused by a medical condition – including treatable ones.
- Person-centered switch:
  - Aggression– "Client is very assertive about his needs."
  - Hostility- "Client is slow to trust others due to an extensive history of childhood abuse."
  - Embellishment of symptoms?- "Client presents with unusual symptoms, which we will investigate. Cognitive decline may affect the way the client observes his symptoms and signs, what he thinks he should report, and the way he recalls and reports them."

DISCUSSION

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