CASE FIVE

Short case number: 3_15_5
Category: Mental Health and Human Behaviour
Discipline: Psychiatry
Setting: General Practice
Topic: Personality disorder_difficult patient behaviours.

Case
Jack Archer, 22 years old as a waiter at the local RSL club who is an inconsistent attendee at your practice. He had a history of substance misuse and usually requests medical certificates to cover his work absences from work. He is often disruptive in the waiting room, and tends to become demanding with staff if he is not seen within 30 minutes of arrival. Some staff members, find him difficult while others feel sorry for him. They are generally afraid he will threaten to commit suicide if his wishes are not met (as he has often done this in the past). He has not had a diagnosis of any mental health problem. Now, Jack presents requesting a prescription for alprazolam. He says he visited the hospital ED who recommended alprazolam for anxiety but lost his discharge note.

1. How would you respond to Jack's request for alprazolam? What further questions would you ask and what information would you seek?

After your above assessment and discussion with Jack you decide not to prescribe him the alprazolam. He quickly becomes upset and agitated. He says he will not be able to cope without the medication, and that he may be driven to suicide if you do not prescribe it. He says you will be found to be a negligent doctor if you do not prescribe the medication for him.

2. What is your differential diagnosis for Jack that would explain is history and current presentation?

3. What strategies would you use to manage Jack's current behaviour in your office?

Unfortunately despite the above strategies, Jack storms out of your office and pushes past one of your colleagues in the corridor causing him to fall into the wall. Jack yells, "Get out of the way", and holds up his fists like he is going to punch someone.

4. How would you manage Jack's current violent behaviour?

Jack has now left the practice but everyone is feeling threatened by Jack.

5. How will you manage this situation going forward? Think about whether you will keep Jack as a patient, and if not how you manage this? Is there anyone else you should inform?

Suggested reading:

1. Management of Mental Disorders (5th edition) World Health Organisation, Collaborating Centre for Evidence in Mental Health Policy. Sydney 2013
2. Hulbert C, Carr N, Managing Difficult Behaviours, Chapter 18 in Blashki G, Judd F, Piterman L. *General Practice Psychiatry*. McGraw Hill. Australia. 2007

Other resources used

http://www.health.vic.gov.au/mentalhealth/mhact2014/

GP notebook UK – Personality disorders
http://www.gpnotebook.co.uk/simplepage.cfm?ID=1630863372

Managing challenging interactions with patients BMJ 2013;347:f4673

Wilhelm K, Tietze T (2016). *Difficult doctor-patient interactions-Applying principles of Attachment-Based Care.* Medicine Today, 17(1-2): 36-44.

ANSWERS

1. **How would you respond to Jack's request for alprazolam? What further questions would you ask and what information would you seek?**

   Ask him what he hopes to achieve by taking the medication (including: Why alprazolam? Is he suicidal? Is he seeking to help with anxiety or depression or sleep? Is he seeking to modify withdrawal? Is he taking any other sedatives, including alcohol? Has he taken it before? Is he aware of potential for dependence? Does he know what the problem is? What else is he doing to help his problem?)

2. **What is your differential diagnosis for Jack that would explain is history and current presentation?**

   Drug seeking per se or in the context of:

   Substance misuse disorder (sometimes called Substance Use Disorder/SUD), including current intoxication (leading to disinhibition, irritability, impulsiveness, delirium, paranoid ideation/psychosis) or dependence (leading to craving and/or withdrawals) which is affecting his behaviour.

   Personality disorder

   Everyone has personality traits - enduring patterns of perceiving, relating to and thinking about the environment, oneself and others - that characterise them. These are the usual ways that a person thinks and behaves, which make each one of us unique.

   Personality traits become a personality disorder when these enduring patterns of thinking and behaving are extreme, inflexible and maladaptive. When present, they cause major disruption to a person's life (work, interpersonal relationships, and family) and are usually associated with significant distress —often more distressing to others than to the individuals themselves (e.g., as in the case of antisocial PD). Symptoms vary from suspiciousness and reluctance to trust others (in paranoid personality disorder), to deceitfulness and failure to conform to social norms in respect to lawful behaviour (antisocial personality), to a pervasive pattern of instability in interpersonal relationships (borderline), to social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation by others (avoidant).

   Personality disorders begin in childhood and persist throughout adulthood.

   The prevalence of personality disorders is not firmly established and varies for the different disorders.

   - Cluster A comprises paranoid, schizoid and schizotypal PDs. These patients present as odd, erratic and eccentric.
   - Cluster B comprises antisocial, borderline, histrionic and narcissistic PDs, defined by dramatic, emotional and erratic traits and behaviours. These patients are frequently seen as problematic by GPs. Their behaviours include anger, verbal aggression, inappropriate

demands, demandingness, sense of entitlement, drug seeking, repeated self-harm, and flirtation.

- Cluster C comprises avoidant, dependent and obsessive compulsive PDs. These patients present as anxious, ineffectual and fearful.

Jack's behaviour fits with Cluster B (borderline PD), with drug-seeling behaviour. This could also been seen as a dismissive attachment style (see Wilhelm and Tietze paper). It needs to be clarified if he has SUD, and anxiety or depressive disorder.

3. What strategies would you use to manage Jack's current behaviour in your office?

Patients with borderline personality disorder (BPD) often have challenging behaviours in GP settings. They are extremely sensitive to changes in interpersonal relationships, feeling easily rejected and abandoned (e.g., by a change in appointment, clinician going on holidays) resulting in dramatic emotional responses such as anger or self-harm. They don't tolerate being alone but their relationships are intense, unstable and change very quickly from admiration or love to anger and hatred. They can be seductive ("you are the first person that really understands me", "I have never told this to anyone") and want to be "special" but are also impulsive and reckless (gambling, substance misuse, unsafe sex). As a result, they are difficult to treat, often eliciting in the clinician intense care responses or rescue fantasies - at least initially - which are unrealistic but often result in an escalation of the patient's emotional demands.

Dealing with patients with BPD:

- Convey a sense of warmth and respect for patient but maintain a professional attitude and distance
- Sound calm and speak moderately, keeping your statements clear and brief
- Be clear in your own mind about what your position is
- Consider whether he is presently intoxicated (and ask him when he last took substances)
- Avoid being drawn into problem solving, prescribing and so on before you have established an understanding of the patient's situation
- Inform the patient of relevant constraints in relation to your role, available time, facilities and treatment options
- Stick with your agenda: be very clear about role boundaries and behavioural limits
- Be consistent

4. How would you manage Jack's current violent behaviour?

Tell him it is completely unacceptable to threaten staff, patients, anyone.
Ask him what he is trying to achieve.
Find out about family experience of violence (who else in his life has behaved like this).
Set boundaries, which should be achievable and applied consistently and by all members of the team.
Find some common ground and common (acceptable) goals. As soon as there is some overlap and common ground, the difficulty rapidly diminishes. This will involve discussion of benzodiazepine seeking and telling him this is also not acceptable.
Focus on finding solutions rather than areas of disagreement. A solution-focused process demonstrates that you are working as a team with the patient. Encouraging the patient to come up with options and working together to agree a solution that is acceptable to both parties can relieve the doctor of being the sole solution maker.

Jack may threaten to go and see someone else: you can say you are happy to treat him (unless you feel it is that is dangerous). He may also threaten suicide: you can have a staff member call the police or mental health helpline, depending on circumstances and you can write a Schedule under Mental Health Act.

This material for nurses has some good points.
https://www.health.qld.gov.au/__data/assets/pdf_file/0031/444586/aggressive.pdf

5. **How will you manage this situation going forward? Think about whether you will keep Jack as a patient, and if not, how you manage this? Is there anyone else you should inform?**

This will depend on how Jack has responded to the questions above, whether you have been able find some common ground
If Jack is agreeable, he may need referral to D and A services and/or DBT program. This may require a motivational interviewing approach to work out where to start.
Continue to be consistent: don't promise anything you can't deliver, be prepared to let patient know of changes, holidays in advance
Do your best to avoid power struggles
Rehearse in advance how to respond to key situations that you can anticipate.
Discuss situation with senior doctor/supervisor as junior doctor, peers as senior doctor
Discuss with MDO useful if there are ethical dilemmas, threats to you/staff
You may also discuss with Medical Council if required.