MANAGING PATIENTS WITH MALADAPTIVE COPING

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Caring for patients who are difficult to care for

“"The doctor doesn't need to examine your hand. The pain is most likely from hitting the call button over 50 times in the last hour."
OUTLINE

1  |  Examples
2  |  Aetiology
3  |  Management
4  |  Self-care
DIFFERENTIAL DIAGNOSIS

- Organic disorder eg delirium +/- dementia
- Substance misuse
  - Intoxication or withdrawal
- Psychiatric disorder eg Anxiety/depressive disorder
- Personality factors
  - Maladaptive coping strategies
General Principles of Care

• ‘Do no harm’

• Dignity & Respect

• Safety of patient

• Safety of staff
Informed Consent

- **PRINCIPLE OF SELF-DETERMINATION**

  An adult has the right to determine for themselves what should happen to his/her body

- Consent enables treatment & investigation to lawfully take place

- Consent requires that a person is adequately informed has the **capacity** to make the decision makes the decision voluntarily
Capacity in Healthcare

- Is the ability to understand relevant information & to appreciate the consequences of a decision
- Ability to believe the information presented
- Ability to weigh up the information in the balance
- Ability to retain the information so that an informed decision can be made
- Ability to communicate the decision
Treatment When a Patient Lacks Capacity

• If a patient lacks capacity no one can give consent on his/her behalf

• PRINCIPLE OF NECESSITY allows for treatment in these cases on the basis that treatment was given in the ‘patient’s best interests’

• BEST INTERESTS ‘necessary to preserve the life, health or well-being’
  Bolam Test-’ Would the judgement of the doctor/nurse coincide with that of a responsible body of medical opinion’

• In difficult/complex cases a second opinion should be sought

• Advisable to consider any wishes previously expressed by the patient & to seek the advice of the patient’s relatives
  However, relatives have no right to consent on behalf of the incompetent patient
Increased risk

if

- Personal/family hx of mental health problems
- Substance misuse
- Adverse social circumstances

- Unpleasant/demanding Rx
- Certain drug Rx eg steroids
3 PROTOCOLS BH on Q Pulse

MANAGEMENT OF ACUTE BEHAVIOURAL DISTURBANCE

1. Look for Possible Causes
2. Seek Expert Advice

PAIN?

- Infection?
- Metabolic? (Sodium, calcium, hypoglycaemia)

CONSTIPATED?

- Alcohol/Drug Withdrawal

IATROGENIC?

- Be suspicious of all prescribed drugs, new prescriptions or abrupt stoppages

DELIRIUM

- Anti-social behaviour
- Consider Security / Gardai involvement

OTHER CAUSES

- Acquired Brain Injury?
- Agitated Depression?
- Acute Psychosis?
- Drug induced (Urine drug screen)
- Personality Disorder

Can you Modify & De-escalate the Environment

- Nurse in a quiet, well lit side room if possible
- Is your patient too HOT/COLD/HUNGRY/IN PAIN?
- Can the FAMILY stay with the patient for a period?
- Consider 1:1 SUPERVISION

- Keep SECURITY GUARD involvement to the background if safely possible

DRUG TREATMENT

- If possible, offer oral medication first before proceeding to IM
- Lorazepam 1-2 mg PO/IM (1 mg PO/IM if delirium)
- Wait 20 minutes, monitoring vital signs every 5-10 minutes if possible
- Above steps can be repeated up to a maximum of twice at 20 minute intervals
- ECG monitoring required if giving repeat doses of Haloperidol to detect Protracted QT or arrhythmias
- Monitor oxygen saturation, heart & respiratory rate

* For Rapid Control

- All procedures during sedation should be SLOWLY
- lorazepam 0.5-1 mg PO/IM
- haloperidol 1-2 mg PO/IM
- If necessary, repeat after 20 minutes
- ECG monitoring if giving repeat doses of Haloperidol to detect Protracted QT or arrhythmias
- Consider regular maintenance treatment if precipitant remains but achieve medications daily
- Aim to discontinue the medication prior to discharge

NOTES

- Only use physical restraints if patient lacks capacity and is at risk of harming themselves or others
- NB There is a duty of care to a patient who lacks capacity and is refusing emergency treatment
- If diagnosis is unknown or there is uncertainty about past medical history (e.g. head injury or cardiac disease) then use only benzodiazepines for sedation
- Sedation with caudal in the elderly (e.g. Lorazepam 0.5-2 mg) or if significant liver disease

Department of Psychiatry / Intensive Care Medicine Sept 2011
Post-incident

- REPORT INCIDENT
- Discussion including senior staff
- Review treatment
- Discuss with family
- Return to work post incident
- REGULAR PATIENT REVIEW
## Model of Care of Psycho-Oncology

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<tr>
<th>Symptom</th>
<th>Level</th>
<th>Intervention</th>
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<td>Transient Distress</td>
<td>1</td>
<td>Patients &amp; Families education</td>
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<tr>
<td>Persistent Mild Distress</td>
<td>2</td>
<td>Cancer team (Education &amp; Training)</td>
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<td>Moderate Distress</td>
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Specialist Treatments

- Problem solving discussion
- CBT for
  - psychological complications
  - to help cope with chemotherapy and other unpleasant treatments
- Joint/ family interviews
- Group support and treatment
- Effective medication for pain, nausea etc
- Antidepressant medics
DIFFERENTIAL DIAGNOSIS

- Organic disorder eg delirium +/- dementia
- Psychiatric disorder eg Anxiety/depressive disorder
- Substance misuse
  - Intoxication or withdrawal
- Personality factors
  - Maladaptive coping strategies
Variety of Responses

The glass is half full! The glass is half empty.

Half full... No! Wait! Half empty!... No, half... what was the question?

Hey! I ordered a cheeseburger.
Considerable individual variation
- Biological
- Psychological
- Environmental
- Social
Abnormal if “inappropriate or maladaptive”

- According to whom? (doctor v patient?)
- May be *adaptive* under certain conditions
PERSONALITY STYLES

1. **Narcissistic** / Confident
2. **Schizoid** / Retiring
3. **Schizotypal** / Eccentric
4. **Avoidant** / Shy
5. **Dependent** / Cooperative
6. **Paranoid** / Suspicious
7. **Antisocial** / Non-conforming
8. **Sadistic** / Assertive
9. **Melancholic** / Pessimistic
10. **Masochistic** / Aggrieved
11. **Negativistic** / Skeptical
12. **Compulsive** / Conscientious
13. **Borderline** / Capricious
14. **Hypomanic** / Exuberant
• **Narcissistic/confident**

Expressively Haughty (e.g., arrogant, supercilious, pompous, and disdainful manner, flouting conventional rules of shared social living, viewing them as naive or inapplicable to self; careless disregard for personal integrity and a self-important indifference to the rights of others).

Interpersonally Exploitive (e.g., feels entitled, unempathic, expects special favours without assuming reciprocal responsibilities; shamelessly takes others for granted and uses them to enhance self and indulge desires).

• **Paranoid / Suspicious**

Expressively Defensive (e.g., guarded, alert to anticipate and ward off expected malice, and deception; tenacious and firmly resistant to sources of external influence and control).

Interpersonally Provocative (e.g., bears grudges and is unforgiving of those of the past, but displays a quarrelsome, fractious and abrasive attitude with recent acquaintances; precipitates exasperation and anger by a testing of loyalties and an intrusive and searching preoccupation with hidden motives).

• **Dependent / Cooperative**

Expressively Incompetent (e.g., withdraws from adult responsibilities by acting helpless and seeking nurturance from others; is docile and passive, lacks functional competencies, and avoids self-assertion).

Interpersonally Submissive (e.g., needs excessive advice and reassurance, as well as subordinates self to stronger, nurturing figure, without whom may feel anxiously alone and helpless; is compliant, conciliatory and placating, fearing being left to care for oneself).

• **Antisocial / Nonconforming**

Expressively Impulsive (e.g., is impetuous and irrefrangible, acting hastily and spontaneously in a restless, spur-of-the-moment manner; is short-sighted, incautious and imprudent, failing to plan ahead or consider alternatives, no less heed consequences).

Interpersonally Irresponsible (e.g., is untrustworthy and unreliable, failing to meet or intentionally negating personal obligations of a marital, parental, employment or financial nature; actively intrudes upon and violates the rights of others, as well as transgresses established social codes through deceitful or illegal behaviors).
SOMETIMES THE KEY TO UNDERSTANDING ILLNESS LIES OUTSIDE THE DISEASE MODEL

IT IS MORE IMPORTANT TO KNOW WHAT SORT OF PATIENT HAS THE DISEASE THAN WHAT KIND OF DISEASE THE PATIENT HAS

Dr Caleb Parry
Powerlessness - Dependency

Trust and Safety

Self-reliant

Need help from others

‘survival depends on compliance with the health care system demands’
Susan Stapleton
Powerlessness - Environment

Hospital

Structure and routine → Culture → Anxious and vulnerable

‘suddenly immersed into the medical world, something most people are unprepared for’
Tamara McClintock Greenberg
• Being ill is demanding, may not have the energy to address emotional issues

• Adopt concrete way of operating, more sensitive to intrusion leaving less emotional space for reflection

• Feeling helpless and/or powerless
Lesson 3 The Autonomic Nervous System

**Symptoms of a Panic Attack**

- heart palpitations or pounding heartbeat
- numbness or tingling sensations
- chills or hot flashes
- sweating
- trembling or shaking
- sensations of shortness of breath or smothering
- feeling of choking
- chest pain or discomfort
- nausea and upset stomach
- dizziness, unsteadiness, lightheadedness, or faintness
- feelings of unreality or being detached from oneself
- fear of losing control or going crazy
- fear of dying

**Stand your ground, defend your position, attack, dig in, persevere!**

**Give way, retreat, discard, remove yourself, give up, move on.**

January 2012
Unhelpful Thinking Mistakes

• *When we are distressed our thinking often becomes distorted*

• Have thoughts that are not true or not completely true

• See problems where there are none

• Blow real problems out of proportion
Powerlessness - Behaviour

Passive

• Follow direction without comment or question
• Can’t make small decisions when invited to do so
• Fail to seek information
• Fail to share information

Aggressive

• Anger
• Frustration
• Aggression towards others
• Nonadherence
• Silence/Verbal
Is this a normal reaction to cancer?

Dr Siobhan MacHale
Consultant Liaison Psychiatrist
Beaumont Hospital

Predisposing Factors
- Biological Factors
- Environmental Factors

Precipitating Factors
- Stress
- Allostatic Load

Secondary Attachment Strategies
Perpetuating Behaviors

Mentalizing Impairments
Attachment style and mentalizing emotions

Deactivating

focus on cognition to neglect of affect

Hyperactivating

focus on affect to the neglect of cognition
Figure 2. Hierarchy of relationships associated with high attachment anxiety in dependent/sociotropically depressed individuals.

Figure 3. Hierarchy of relationships associated with attachment avoidance in self-critical/autonomous depressed individuals.
Is this a normal reaction to Cancer?

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Advanced Cancer Requires Coping With

• Physical symptoms
  – pain, fatigue

• Psychological
  – fears, sadness

• Social
  – family, future

• Spiritual
  – seeking comforting philosophical, religious, or spiritual beliefs

• Existential
  – seeking meaning of life in the face of death
EXISTENTIAL CRISES IN CANCER

Adapted from McCormick & Conley, 1995
COPING

- ADAPTIVE
- Reduce stress & increase function

- MALADAPTIVE
- Temporary relief of symptoms & reduce function
ADAPTIVE COPING STYLES

• Problem Solving

• Emotion Focused Coping
  strategies to manage how we are feeling when we can't solve the problem

• Avoidance
  really good coping strategy if we use it some of the time

+/- Making Meaning
COPING

- ADAPTIVE
  - Reduce stress & increase function

- MALADAPTIVE
  - Temporary relief of symptoms & reduce function
Attachment hyperactivating and disorganized strategies

- “catastrophizing”
- Clinging, claiming relational style: idealization-denigration cycles
- Lack of “broaden and build”
- Often considerable trauma history
- Dependent/borderline features
Borderline personality disorder

Significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour

Pattern (sometimes rapid fluctuation)
• from periods of confidence to despair
• with fear of abandonment and rejection
• a strong tendency towards suicidal thinking and self-harm

• Transient psychotic symptoms, including brief delusions and hallucinations, may also be present.
• Substantial impairment of social, psychological and occupational functioning and quality of life.
People with borderline personality disorder should not be excluded from any health or social care service because of their diagnosis or because they have self-harmed.

DBT teaches skills to control intense emotions, reduces self-destructive behaviors, and improves relationships.

Managing Intense Emotions and Overcoming Self-Destructive Habits
A Self Help Manual    Lorraine Bell
AIMS OF INTERVENTION

• ACTING OUT
• SPLITTING
• NONADHERENCE
• HIGH DOSE MEDICATION
• DISABILITY

ENGAGING WITH DISTRESS
BROADEN AGENDA
PROBLEM SOLVING
INVOLVE RELATIVES
STAFF SUPPORT

INFORMATION

BIO-MEDICAL

PSYCHO-SOCIAL
MANAGEMENT: 2 GROUPS

1. Those who can develop insight and work with biopsychosocial management

2. Those who cannot (a minority)
Carers needs

• Family

• Mental health of Staff
  - Physicians’ acknowledged feelings (anger, frustration, depression)
  - Affect
    Clinical decisions
    Behavior with patients
    Quality of care
    Risk of burnout

Meier et al, 2002
In health care settings we are often focused on helping others, we fail to care for, nourish and replenish ourselves in order to mitigate the occupational hazards of our profession and thrive within our work.

“self-care is an ethical imperative for (social workers) given the innate occupational hazards relevant within our field including job stress, professional burnout, primary trauma, vicarious trauma and compassion fatigue.

For many (social workers), the nature of the work itself often involves three elements — high stress, high trauma (direct or indirect), and high touch (high emotion with emotional labour/caring being a key task within many social work roles)”


Lynda Monk, msw rsw CPC
AS AN EMPLOYEE

Employers have a duty of care but employee also certain responsibilities to ‘take reasonable care for his or her safety, health and welfare, and the safety, health and welfare of any other person who may be affected by the employee’s acts or omissions at work’

*Safety, Health and Welfare at Work Act 2005*
AS A DOCTOR

**Irish Medical Council**
- Professional ethical standards that require drs to exercise self care as one of the 8 domains of good professional practice
- Established Health Sub-Committee to monitor & support

**RCPI**
- Notes drs less likely to access support
- Professional standards include the ability to care for one’s own physical and mental health, recognise stressors and access appropriate supports
- Advises physicians that they have a responsibility to themselves, to their families and their patients to take care of their own health
“The term *self-care* refers to activities and practices that we can engage in on a regular basis to reduce stress and maintain and enhance our short- and longer-term health and well-being. Self-care is also necessary for you to be effective and successful in honouring your professional and personal commitments.”

**How to flourish in (Social Work)**

- **Common Ailments**
  - BURNOUT
  - COMPASSION FATIGUE
  - SECONDARY TRAUMATIC STRESS

- **Steps to self care:**
  - EXERCISE (light)
  - READ
  - LAUGH
  - EAT WELL
  - MEDITATE
  - GREENSPACE
  - SLEEP

Mindfulness & Relaxation Centre (MARC)  www.beaumont.ie/marc

Exercises

Click on the name of an exercise to learn more or listen in....

Relaxation Exercises
- Relaxation Breathing (a good place to start!)
- Active Progressive Muscle Relaxation 1
- Active Progressive Muscle Relaxation 2
- Active Progressive Muscle Relaxation With Music
- Passive Progressive Muscle Relaxation
- Insomnia Progressive Muscle Relaxation
- Nature Visualisation
- Safe Place Visualisation
- Autogenics
- Autogenics With Music
- Clear the Deck Exercise With Music

Mindfulness Exercises
- Mindfulness Introduction
- Sitting Mindfulness
- Mindful Soundscape
- Body Scan
- Mindful Body Scan (recorded live)
- Sitting Mindfulness 2
- Moving Mindfulness
Discussion