Breaking Down Difficult Encounters

Managing controlled medications, and bringing awareness to the internal and external forces at play

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Objectives

- Define and Discuss *Patient Centered Care* and *Trauma Informed Care*
- Explore factors that contribute to a difficult clinical encounter
- Identify implicit associations which can impact care
- Discuss PTSD treatment; Review research findings and identify gaps in guidelines
- Discuss psychological dynamics at play during a clinical encounter
- Review strategies for navigating difficult encounters

Frameworks

- **Patient centered care:**
  - Centering the needs and desires of our patients
  - What does PCC look like when we may be denying the patient the one thing they came to the visit to ask for?
- **Boundaries and protection for providers**
- **Trauma informed care**
  - Do no harm and work to not retraumatize people
  - Recognize that a majority of our patients have a trauma hx
  - TIC asks that we not re-traumatize patients
  - TIC asks that we change systems, including systems of communication, in order to provide best care
  - TIC prioritizes provider well being

What kind of visit stresses you out?

What makes a difficult encounter?

the content, the environment, the context?

What content may be difficult?

- Taper off of a benzodiazepine or hypotonic
- Denying to start a benzodiazepine or hypnotic
- History taking of complex trauma hx
- Navigating DCF involvement
- Racist, sexist, homophobic, xenophobic language

Difficult Environments:

- End of day
- Telephone visit
- Many other people in office
- Political unrest
- Masks
- Literacy issue
- Language Barrier

Word Association with Benzos

Word Association with SSRIs

Association with the Patient?

Do those associations with Benzos vs SSRIs consciously/unconsciously get transferred to our association with the patients themselves?.....

Let's Not Blame the Patient

Between 2014 and 2016 in the US: For every 100 adults that visit an office-based doctor over the course of a year, 27 visits will result in a prescription for a benzodiazepine (https://www.cdc.gov/nchs/data/nhsr/nhsr137-508.pdf)

"What we're seeing is just like what happened with opioids in the 1990s…. It really does begin with overprescribing. **Liberal therapeutic use of drugs in a medical setting tends to normalize their use. People start to think they're safe** and, because they make them feel good, it doesn't matter where they get them or how many they use…What we're seeing is just like what happened with opioids in the 1990s…The number of adults filling a benzodiazepine prescription increased by two-thirds between 1996 and 2013, from 8 million to nearly 14 million, according to a review of market data by Lembke and others in the *New England Journal of Medicine*." (https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/07/18/these-pills-could-be-next-us-drug-epidemic-public-health-officials-say)

Benzodiazepines and PTSD

Benzodiazepines are one of the most common medications prescribed for PTSD patients. Between 30% and 74% of PTSD patients have been prescribed a benzodiazepine in the past.

(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7694098/)

PTSD Treatment Guidelines Lacking

2017 Workgroup on PTSD Psychopharmacology led by Dr. Krystal at Yale School of Medicine, with authors from VAs and Medical Schools across the country, found a “Crisis”::

- Only 2 medications currently approved by FDA for the treatment of PTSD: Sertraline (Zoloft) and Paroxetine (Paxil).
- “Limited efficacy of the FDA-approved treatments for PTSD has necessitated *polypharmacy* for the vast majority of patients treated. These off-label medications, as monotherapy or in combination with other medications, have not been studied adequately for the treatment of PTSD. Therefore, most patients are treated with medications or combinations for which there is little empirical guidance regarding benefits and risks.”

Novel Psychotherapies in the Pipeline

There is a growing consensus among leaders in the field of PTSD research that there are many pharmacologic agents that should be tested as novel pharmacotherapies for PTSD:

- Rapid acting antidepressant mechanisms (ketamine-like drugs, scopolamine)
- Cannabinoid drugs that might have anxiolytic effects or enhance extinction (CB1-R agonists, cannabidiol, FAAH inhibitors)
- Glucocorticoid signaling
- Non-SRI antidepressants/monamine transporter antagonists (trazodone, vortioxetine, cyclobenzaprine, etc.)
- Opioids (buprenorphine, kappa opioid receptor antagonists)
- Riluzole

Benzodiazepines for PTSD: A Systematic Review and Meta-Analysis (2014)

Results:

BZDs are ineffective for PTSD treatment and prevention, and risks associated with their use tend to outweigh potential short-term benefits. In addition to adverse effects in general populations, BZDs are associated with specific problems in patients with PTSD: worse overall severity, significantly increased risk of developing PTSD with use after recent trauma, worse psychotherapy outcomes, aggression, depression, and substance use. Potential biopsychosocial explanations for these results are proposed based on studies that have investigated BZDs, PTSD, and relevant animal models.

Conclusions:

The results of this systematic review suggest that BZDs should be considered relatively contraindicated for patients with PTSD or recent trauma. Evidence-based treatments for PTSD should be favored over BZDs.

Framework for Role of Medications

Bessel Van Der Kolk, MD from *The Body Keeps The Score:*

“Drugs cannot “cure” trauma; they can only dampen the expressions of a disturbed physiology… They can help to control feelings and behavior, but always at a price - because they work by blocking the chemical systems that regulate engagement, motivation, pain, and pleasure”.

Holistic Approach

-Medications have their place

-Psychotherapy; EMDR; etc, etc

-**The therapeutic rapport is a powerful intervention**

Patient Centered:

- Actively and explicitly involve your patients in decisions that effect their care – treat them as valued partners and part of their care team
- Emphasize your concern for the patient's safety
- Reiterate your primary objective – to support them and to help them safely and effectively manage their anxiety
- Be trauma-informed

Context

Structural inequities refers to the systemic disadvantage of one social group compared to other groups with whom they coexist, and the term encompasses policy, law, governance, and culture and refers to race, ethnicity, gender or gender identity, class, sexual orientation, and other domains.

The *social determinants of health* are the conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. For the purposes of this report, the social determinants of health are: education; employment; health systems and services; housing; income and wealth; the physical environment; public safety; the social environment; and transportation

Racism

“Black and Brown communities have been made vulnerable to disease, psychological stressors, and unhealthy behavior, due to the unequal distribution of resources. This unequal distribution is evident in substance use disorder (SUD) treatment as racism at varying levels in the system has led minoritized groups to be historically and systematically excluded from access to treatment. If we are serious about addressing these inequities in treatment, it is imperative that we understand and recognize how economic, physical and sociopolitical forces impact medical decisions”

“Racial Inequities in Treatments of Addictive Disorders” October 1, 2021 Fabiola Arbelo Cruz MD, Yale School of Medicine

Stats

- Study showed that Black patients were 70% less likely to receive a prescription for buprenorphine at their visit when controlling for payment method, sex, and age.
- Study of privately insured people who suffered an overdose and were treated at an emergency room found that Black patients were half as likely to obtain treatment following overdose compared with non-Hispanic White patients.
- Study of benzodiazepine prescriptions for anxiety in an Emergency Department setting showed:
    - Compared with non-Hispanic White patients, non-Hispanic Black patients were 36% less likely to be prescribed a benzodiazepine, and Hispanic patients were 19% less likely to be prescribed a benzodiazepine

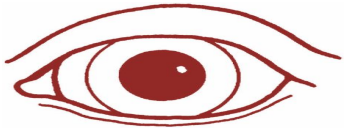
Psychological dynamics at play during a encounter

Trauma responses

- The likelihood that chronic pain, “anxiety” and addictions patients have experienced trauma is high
- The pathophysiology of trauma includes CNS dysregulation

Initial signs and symptoms of the stress response:

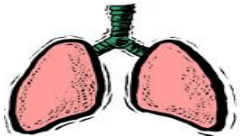
(aka fight, flight or freeze or HPA axis)



Blurred vision

Muscle tension

nausea



shaky

Inability to focus/ think straight

Increased heart rate

Increased blood pressure

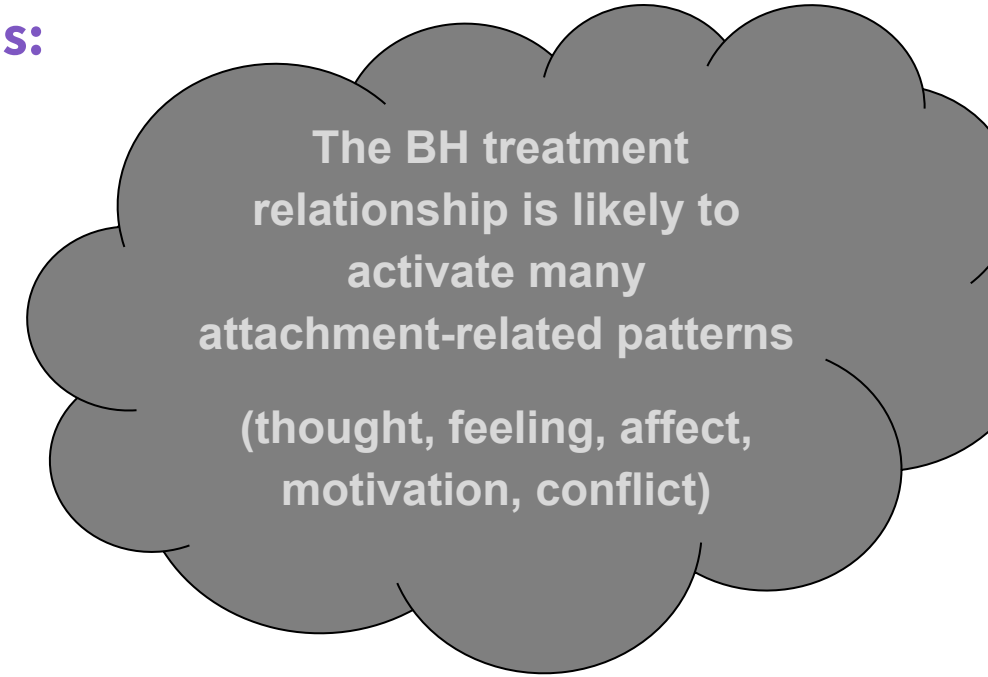
Sweaty palms

Shallow breathing

Lens of Transference and Attachment Structures

Possible Transference Dimensions:

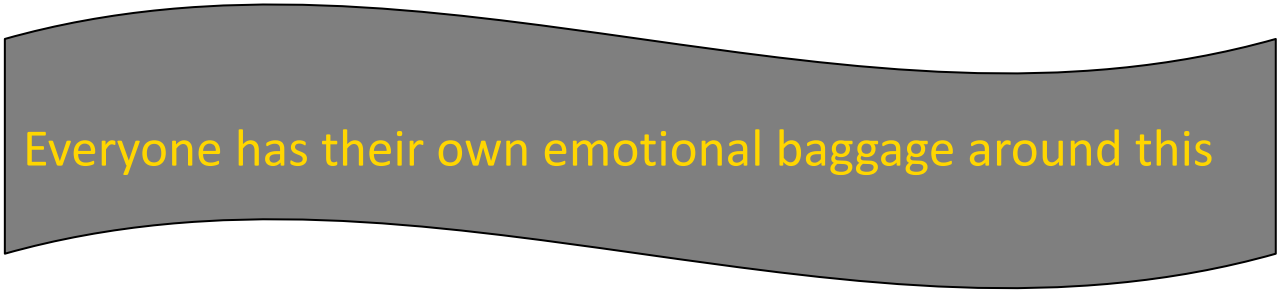
- secure/engaged
- angry/entitled
- anxious/ preoccupied
- avoidant
- sexualized



https://www.cambridge.org/core/services/aop-cambridge-core/content/view/678BA6B1810B8D8157DC461526B14305/S0007125000165870a.pdf/transference_patterns_in_the_psychotherapy_of_personality_disorders_empirical_investigation.pdf

Dynamics/Patterns That Get Triggered

- Seeking vs. fearing change
- Hiding vs. disclosing one's flaws and vulnerabilities
- Depending vs. not depending on an authority figure in an asymmetrical relationship



How to handle the difficult encounter

Before the visit

before the visit

- Ask yourself, “Why do I consider this patient difficult?”
- What biases and assumptions do I have?
- What is *my* agenda?
- Take three deep breaths
- Relieve tension
- Be present

During the visit

Be Clear About Your Impression, What is Clinically Indicated/Safe

Ask if they would like to partner and consider alternative tx possibilities

Take a breath.

How to say no...

What to say to…?

"Do you want me to lose my job, do you want me to be on the street?"

I want you to have safe and anxiety control/emotional regulation and it is my medical opinion that your current medicine won't give you that.

"Do you have Anxiety?"

I want to use every minute of our time today to talk about your anxiety management plan.

"I wish you could feel my pain."

I know you're suffering and I'm sure that we can work together to reduce pain, so you don't have to suffer

Dr. Brad Anderson, MD at Portland Kaiser Addiction Medicine and Lydia Barthow DNP

What to say to…?

Are you accusing me of being an addict?”

I have never accused anyone of depression but I’ve diagnosed them with it and that is what I am trying to now, diagnose a medical illness”

“Don’t label me as a druggie”

I have no interest in labels at all, I am interested in helping people who are struggling with medical problems, such as substance use disorders.

“So you’re basically saying that I’m a junkie.”

I’m saying that addiction is a medical problem that responds to treatment not a problem of bad morals or behavior

Dr. Brad Anderson, MD at Portland Kaiser Addiction Medicine and Lydia Barthow DNP

And if they threaten you…?

"I heard it's illegal for you to let me go into withdrawal."
We will taper you safely. My intention is to do no harm to you.

"I'll just go and use heroin."
I certainly hope you don't because you know that I don't think any type of opiate will help your pain.

"Don't bother with any other meds, I'll just kill myself."
I need to ask you some more questions about your thoughts about suicide.

"I'm getting a lawyer."
You do what you feel is right, of course. That's what I'm doing for you, too.

Dr. Brad Anderson, MD at Portland Kaiser Addiction Medicine and Lydia Barthow DNP

And if this fails…

- Stay in the medical expert role
- Emphasize concern and condition
- Speak to what is behind a patient's comment, not to the comment itself
- Speak to what you know to be true; trust your science

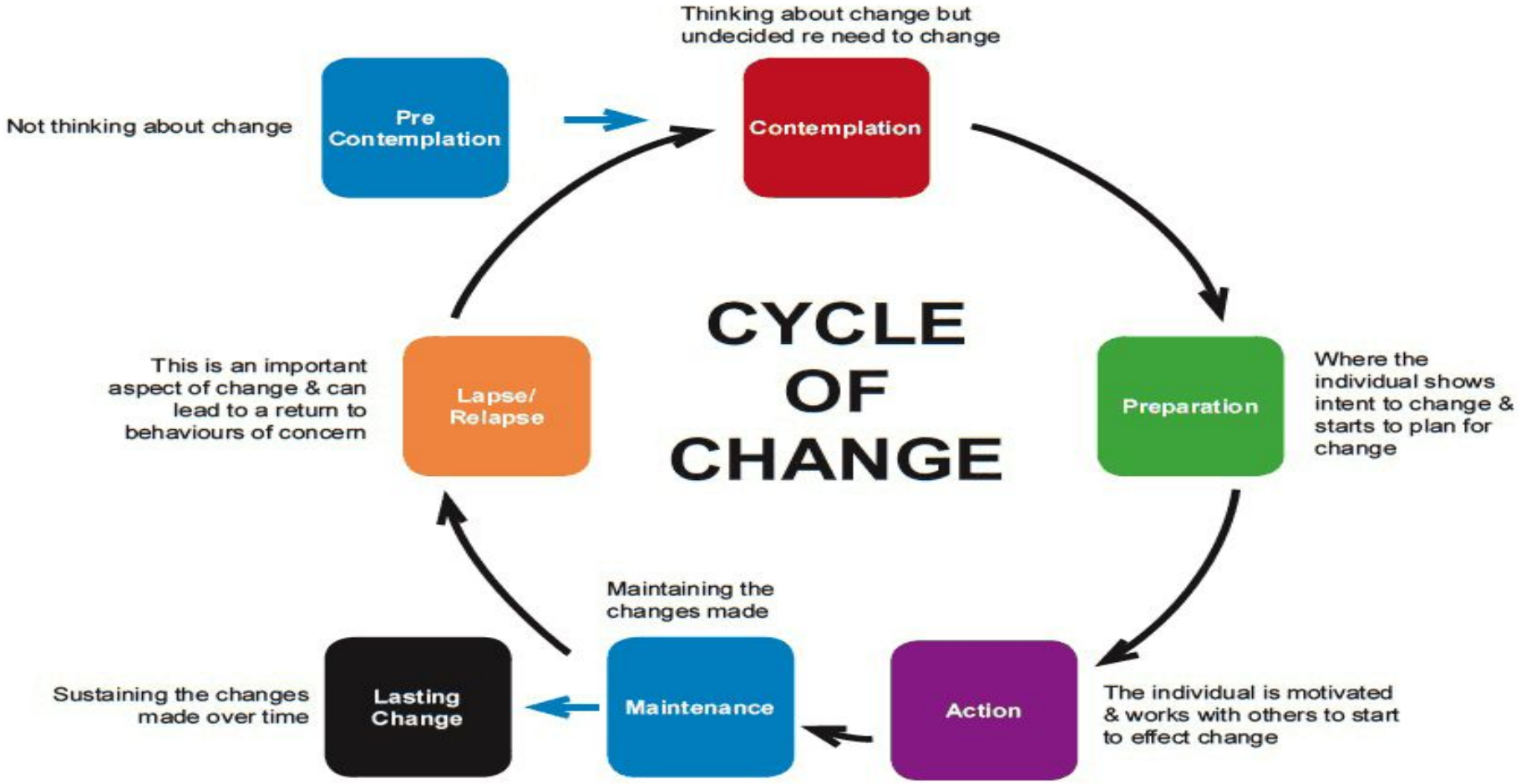
Dr. Brad Anderson, MD at Portland Kaiser Addiction Medicine and Lydia Barthow DNP

Boundaries make everyone feel safer!

“Xanax is off the table. How would you like to spend our office visit today?”

“There is nothing you can do or say to make me prescribe you xanax/increase your dose/give you an early refill”

Strategy	*Physician actions*	*Examples*
Active listening	Understand the patient's priorities, let the patient talk without interruption, recognize that anger is usually a secondary emotion (e.g., to abandonment, disrespect)	"Please explain to me the issues that are important to you right now." "Help me to understand why this upsets you so much."
Validate the emotion and empathize with the patient (understanding, not necessarily sharing, the emotion with the patient)	Name the emotion; if you are wrong, the patient will correct you; disarm the intense emotion by agreement, if appropriate	"I can see that you are angry." "You are right—it's annoying to sit and wait in a cold room." "It sounds like you are telling me that you are scared."
Explore alternative solutions	Engage the patient to find specific ways to handle the situation differently in the future	"If we had told you that appointments were running late, would you have liked a choice to wait or reschedule?" "What else can I do to help meet your expectations for this visit?" "Is there something else you need to tell to me so that I can help you?"
Provide closure	Mutually agree on a plan for subsequent visits to avoid future difficulties	"I prefer to give significant news in person. Would you like early morning appointments so you can be the first patient of the day?" "Would you prefer to be referred to a specialist, or to follow up with me to continue to work on this problem?"


Thinking about change but undecided re need to change
Not thinking about change
Pre Contemplation
Contemplation
CYCLE OF CHANGE
This is an important aspect of change & can lead to a return to behaviours of concern
Lapse/ Relapse
Preparation
Where the individual shows intent to change & starts to plan for change
Maintaining the changes made
Sustaining the changes made over time
Lasting Change
Maintenance
Action
The individual is motivated & works with others to start to effect change

After visit

After care

- Take a breath
- Spray some soothing smells
- Reach out to your supervisor
- Connect with colleague

Other strategies?

Working with your team:

Work closely with patient's therapist

Run questions/concerns by your BH team to get feedback

Leverage the resources of the greater integrated team at your site as applicable and as possible - i.e. RN visits

In partnership with the patient, think through other ancillary services that might be helpful -- i.e. visiting nurse services, case management services

Case examples?

A few last thoughts on thriving in medicine:

- Remember what brought you into this field
- If there are certain areas that bring you particular joy, stay involved in those/get involved in those
- Figure out best ways to maintain good work-life balance for you (everyone is different), for a sustainable and happy career
- Never forget the importance of self care
- Having a supportive team to work with can be key for avoiding burnout and disillusionment

Thank you!

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