mindovermatter

by Professor Gordon Parker

The provocative patient

Treating a patient who feels they've been let down by all.

INTRODUCTION

THE nature of depression usually evokes empathy in the health practitioner.

Most patients, despite debilitating symptoms and the despair associated with depression, seek to relate well to their practitioner. However, some seek to antagonise.

HISTORY

Uri, a 56-year-old male on a disability pension for depression, was referred for a treatment-resistant disorder present for 20 years.

Before assessment he complained about the delay, then, when his appointment was advanced as requested, he complained about the inconvenience. He arrived late and criticised the staff because he had the wrong address.

The interview proceeded with great difficulty. He was only prepared to provide information that suited him and dismissed many questions as irrelevant. Twice he demanded a cigarette break and returned later than requested.

He stated that his depression started following the break-up of his marriage and the loss of work. His depressive symptoms were protean but of moderate severity at worst, and there was no suggestion of a 'biological' mood disorder (e.g. melancholic or bipolar condition).

He had sought assistance from many GPs, psychologists and psychiatrists, and had attended many community health centres, having moved around the state. He detailed his frustrations with all practitioners, and said that none of the many antidepressants trialled had been of benefit.

He had made many formal complaints about government social support services. Only his referring social worker received a positive comment.

He was evasive about his early history, but alluded to a cruel, demeaning and abusive father, and several bullying brothers. He remembered his mother as supportive, but she had died when he was eight. His past and present worlds were polarised (i.e. a supportive mother and social worker versus those who bullied or demeaned him).

Throughout the interview he made little eye contact, and sneered disdainfully at many of the questions. The meta-communication was that he was in control and was not prepared to respect the authority of the assessing doctor. When asked his priorities, rather than treatment of his depression, he prioritised better Housing Commission accommodation.

"If they'd give me decent accommodation, I could get on with my life."

> Such patients present a 'mission impossible' scenario, complaining before, during and after assessment

MANAGEMENT

Such patients present a 'mission impossible' scenario. They complain before, during and after assessment, and by statements and gestures suggest that the interviewer is not on their wavelength.

Their dynamic is to externalise the negative feelings they hold in a 'pass the parcel' strategy to those who deal with them.

The interviewer – and the patient's managing doctor – are made to feel impotent, and in response become frustrated and angry. The managing doctor feels provoked, and may be tempted to respond dismissively, angrily or in passive aggressive ways. The patient's 'diagnosis' can be 'felt' in the counter-transference elicited in the doctor.

The macro issue is whether to engage in any management strategy at all or whether to regard the situation as a lost cause. Either way, the immediate issue with Uri was how to terminate the consultation and avoid any ongoing responsibility for what would clearly be of no benefit, but replete with demands and complaints.

It is possible in such instances to find at least one untrialled medication and offer it with a recommendation that it might be of some benefit. This achieves certain aims – indicating that a management strategy has been identified, that the doctor is working to their expertise (i.e. prescription of a drug), and brings closure to the assessment.

However, aimed at the declared presenting problem (treatment-resistant depression), such a strategy is beside the point.

In Uri's case, his principal 'identified' problem (housing) was taken as the key priority, and a second and third priority identified, with a 'project management' model put to him for addressing each.

For housing, he had one solution – wrangle with Housing Department staffers, who would, in turn, probably respond to his provocation with reasons for rejecting his applications, and the 'game' would go on.

In any event, Uri was given several alternative strategies for each of the identified priorities, and these were detailed in a letter to his social worker.

Uri left, dismissive of the suggested plans. At one level, not much had been achieved.

However, it could now be documented that there was no need for his managing doctors to pursue a treatment-resistant depression model and that he had been offered a self-management model, rather than doctor-imposed 'treatment' that he was so used to rejecting. If he rejected the approaches suggested, then he – who set up 'Hobson's choice' scenarios with his managing doctors – was exercising his own choice in the matter.

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