

## Chapter 11

# THE 'DIFFICULT' PATIENT AND CONTEXTUAL REFORMULATION

### SUMMARY

*The 'difficult' patient is not a diagnostic entity but may be recognised in a variety of patient groups and settings. Although 'difficulty' is usually attributed to the patient, it is invariably a systemic phenomenon and may be accounted for from a CAT perspective in terms of the elicitation of either reciprocating or identifying countertransference role enactments from those around them. Characteristically, these reactions split and demoralise staff teams and may also involve other agencies such as social workers, hospital managers or the police. CAT-based approaches to such patients include the use of the tool of extended, contextual reformulation, mapping out these various, elicited reciprocal role enactments. These are constructed on the basis of discussion with those involved in addition, where possible, to work with an individual patient. This approach can be effective in understanding apparently incomprehensible behaviours as well as containing and illuminating some of the powerful feelings that may be elicited. Use of a contextual reformulation may enable staff to respond therapeutically rather than simply react to such patients. It may also be useful in consultative work around, for example, severe personality disorders and exemplifies a trend towards 'using' CAT in contrast to simply 'doing' it as an individual therapy.*

The 'difficult' patient is not a diagnostic entity but rather a label which tends to be applied to patients when particular sorts of interpersonal or professional difficulties are created around them. These may also lead to patients being described as 'hard to help', 'heartsink', 'manipulative' 'attention seeking' 'acting out' and so forth. A point of particular importance in considering such

patients is that the difficulty rarely resides in the individual patient, although others might like to locate it there, but rather in a system. It is therefore always germane to enquire whose difficulty it really is. Patients frequently do not regard themselves as having a problem, although this may actually constitute part of the 'difficulty'. This has already been alluded to in the context of the 'frequent attender' patient in general practice who often has underlying psychological distress or dysfunction. Such patients are encountered in various settings and contexts and with various sorts of problems, although some are more likely to acquire such a label than others. The category would include most notably patients with severe personality disorder, eating disorders, those with somatising disorders, some psychotic disorders but also some with neurotic disorders such as anxiety and depression. Similar problems may also arise as a complication in almost any physical illness, especially if chronic.

Tolstoy observed that all unhappy families were different in their own ways. It is also the case that each difficult patient, or rather the difficulty surrounding him or her, is difficult in its own way. Nonetheless, one may attempt to list the sort of ways in which such difficulty manifests. Broadly speaking there are two categories according to whether reciprocating or identifying countertransference responses are elicited from those around them:

1. One group consists of patients who are 'non-compliant' and may sabotage treatment, those who aggressively demand more but may 'rubbish' any attempts to help, or patients who deny any psychological distress or difficulty but who still insist on 'help' on their own terms. These patients typically elicit frustrated, irritated, rejecting and sometimes cynical reactions from some staff who may also criticise other staff who are more sympathetic. These 'reactions' can all be described in terms of reciprocal role enactments.
2. The other group includes the 'helpless', 'needy' patient who elicits often heroic but inappropriate reactions in staff who may become over-involved and helpful beyond appropriate professional boundaries, and who may criticise other staff for not appreciating the patient's plight. Over-involved reactions can perpetuate the 'helplessness' or 'neediness' of a patient, for example by doing shopping for them or negotiating with other professionals such as solicitors. To a point these may be reasonable things to do and may acknowledge a patient's, perhaps very difficult, real life circumstances and sense of powerlessness (see Hagan and Smail, 1997). When this becomes a dominant mode of interacting with a patient, however, it constitutes a largely unhelpful, collusive role enactment.

These elicited reciprocations, or countertransference role responsiveness (Sandler, 1976), around the 'difficult' or 'special' patient, in particular the way in which counterproductive and divisive reactions are elicited or 'provoked' in staff teams, have been described in the past from a predominantly

psychoanalytic perspective. Main's classic paper (1957) 'The Ailment' was an early example and they have been discussed more recently by Pines (1978), Norton (1996), Hinshelwood (1999) and reviewed also in Hughes and Kerr (2000). These consequences include the splitting of teams into those reacting in one of these two countertransferential ways and subsequently, very often, to staff exhaustion and 'burn out'.

As already discussed, the CAT approach of explicit reformulation of the reciprocal role procedures (RRPs) of an individual patient can be useful in working jointly with such patients and their treating teams. In addition, the basic tool of the sequential diagrammatic reformulation (SDR) may be extended into a formal 'contextual' reformulation which describes and maps in addition the responses of treating staff and possibly also the responses, in turn, of other agencies in terms of reciprocal role enactments. These others may include hospital managers, casualty staff, ancillary staff such as receptionists in GP or hospitals, police, social workers or even the general public (Dunn and Parry, 1997; Kerr, 1999). Contextual reformulation may also include the mapping out of interactions with family members who may play a critical role in such difficulty. Clearly such an approach comes close to describing the sorts of interactions addressed, although not formally mapped, in family and systemic therapies. It also has some parallels with the approach advocated by Norton (1996), who describes such clinical transactions as 'complicated', as opposed to 'straightforward', and notes the helpful effects of mapping the personal and public responses of both patient and professional in a 'transaction window'.

One of the important effects of a contextual approach is to locate the difficulty in a dynamic system explicitly describing various role enactments in a way which permits the owning of 'difficult' counter transference '*reactions*' and turning them into collaboratively worked on and jointly understood '*responses*'. Examples of this approach and the principles of constructing such contextual SDRs will be given below. In considering the difficult patient or client, however, it is useful to consider first the background causes of such difficulty and the general principles involved in working with this undoubtedly fraught and 'hard to help' group of patients.

## CAUSES OF DIFFICULT BEHAVIOUR

### Physical causes

It is important to remember that changed or difficult behaviour, particularly if of recent onset, may be the result of physical factors. These could include serious infections, pain, intracerebral pathology (such as a mild stroke) as well as the effects of medication (see review in Kerr and Taylor, 1997).

## **Psychiatric causes**

Major psychiatric disorder, whether long-standing or of recent onset, may contribute to the appearance of difficulty (e.g. 'sabotaging' treatment), although this may also be due to an acute illness. However, patients suffering from severe or acute psychiatric disorders may also create 'difficulty' for the psychological reasons discussed above, and unpicking these from the effects of a major disorder can be a major and challenging part of work in this area (see Chapter 9). Psychological problems may include such general issues as anxiety or hopelessness, anger, feelings of hurt, being misunderstood or not listened to in the context of illness, whether physical or mental, through to existential issues of meaning and purpose in life.

## **Staff team dynamics**

Finally, it is also important to consider 'iatrogenic' causes of difficulty, including individual staff and/or institutional psychopathology. The latter may include inadequate communication between various members of staff, differences of opinion between staff regarding diagnosis or treatment, or anxiety generated by excessively authoritarian team and management structures as described classically by Menzies-Lyth (1959/1988). These problems may determine the extent to which staff are drawn into, or elicit, antagonistic or apparently sabotaging behaviour on the part of a patient (see Norton, 1996; Hinshelwood, 1999; Kerr, 1999).

## **GENERAL APPROACHES TO THE 'DIFFICULT' PATIENT**

In general, approaches to the 'difficult' patient (bearing in mind the caveats above regarding the systemic aspects of such difficulty) would include the following: (1) use of a firm but empathic, non-confrontational style; (2) jointly agreed definition of common treatment goals and of limits and boundaries (where, for example, the responsibility of a therapist or nurse begins and ends); (3) facilitating the ventilation and exploration of underlying concerns and issues by the primary treating team; (4) drawing patients' attention firmly but gently to the effects of their behaviour on staff and how it affects attempts at treatment or investigation; (5) if necessary, offering specialist psychotherapy individually with the patient in a standard CAT approach; or (6) undertaking a contextual reformulation with the team.

## **CONTEXTUAL REFORMULATION**

Contextual reformulation is an approach which has evolved out of attempts to address more complex processes involved in the perpetuation and exacerbation

of an individual's psychopathology. In part this represents an obvious extension of the pioneering work of therapists such as Walsh, who used CAT-based approaches to address and work with organisational 'pathology' (Walsh, 1996). It also has parallels with the theory and practice of family and systemic therapists and, to a lesser extent, with group analysts. The common aim of these approaches would be to understand and acknowledge the self-reinforcing role enactments of other individuals and agencies involved around a given patient. In systemic approaches these would not normally be formally mapped out nor an explicit account given in psychodynamic terms of various behaviours. In CAT these would be implicit in an individual SDR, since every patient of course brings a repertoire of role enactments, each seeking the response of others, both from their past and in the present. It can be helpful to map out these extended role reciprocations explicitly, as far as possible in a collaborative manner. One of the striking effects of so doing is, as noted by Walsh (1996), the location of various individual reactions in a non-judgemental system of causality. It also permits the owning of 'negative' emotions and reactions, parallel to those discussed by Winnicott (1947) under the rubric of 'hate in the countertransference', and permits open discussion of them by a treating team or other involved agencies. It can stimulate imaginative discussion of *what it is like to be that patient*, even if the patient remains reluctant to open up or engage. This can in itself be remarkably illuminating and thought-provoking for staff. Contextual reformulation can also help staff to avoid getting stuck in 'collusive', negative, vicious circles ('traps') in reaction to 'difficult' behaviour by a patient in the way that a good SDR can help an individual patient. It can thus have an educative function for staff and create a shared understanding so, in turn, creating or strengthening a therapeutic working alliance and communicating that the patient has been listened to and understood. As with individual SDRs, the effects of these on staff teams as well as on patients can be both moving and powerfully therapeutic. A good reformulation is a tool which is of use to the whole team.

It is of historic interest that, although Main (1957) was able to identify and describe the difficulties around the 'special' or 'difficult' patient, he was unable to propose any systematic course of action from his contemporary theoretical perspective (see discussion in Kerr, 1999). Experience with these techniques suggests that identifying and mapping out not only the patient's reciprocal role enactments but also those of others around, can be just such an effective approach. Feeling pressurised or confused is bad for staff morale. Reformulation may be helpful to staff simply in avoiding 'burn-out' and bad feelings even if it does not always prove possible to engage and work with a patient who may be too stuck or ill to do so.

## CONSTRUCTING A CONTEXTUAL REFORMULATION

One may start with an individual SDR either created with the patient or, sometimes, by asking a team to imagine what the patient's 'core subjective self'

might be like. This can, in itself, be a fascinating and helpful exercise. In our experience the subjective states and role enactments may be described very broadly in terms of two split halves (rather like narcissistic 'broken eggs') (see Figure 11.1). Thus the patient split would typically divide *hurt, misunderstood, needy* and *anxious* roles from *angry, resentful* and possibly 'non-compliant' and 'sabotaging of treatment' roles. These should all be familiar polarisations to the CAT therapist. Likewise the staff team split very often runs between *caring, sympathetic, 'wanting to do a good job'* role enactments on the one hand and *feeling irritated, frustrated, angry* and *being rejecting* and *being cynical of other staff* on the other. The identification and acknowledgement of these two splits, if possible, is already a considerable achievement.

In the naturalistic studies conducted so far (Dunn and Parry, 1997; Kerr, 1999, 2001), the explicit detailing of a patient's circumstances and story in relation to the staff team (who are under constant pressure to be part of the 'difficulty') has been powerful, engaging and effective for those concerned. More complex diagrams may be required to map out role enactments and reactions around very disturbed patients such as those with severe personality, psychotic or eating disorders.

These may involve self state switches on the part of the patient and also the involvement of many other agencies apart from the immediate treating team, possibly including family members. An example of a more extended or complex contextual reformulation for a patient with personality disorder being treated by a community mental health team is described in Kerr (1999). This approach may constitute the sole intervention by a consulting therapist or team, for example, within a district service (see Dunn and Parry, 1997). With some 'difficult' patients it is possible to use the patient's SDR in discussion with those involved and to note enactments in the team of roles mapped on the patient's SDR. This can be a very illuminating and containing exercise and has been used to good effect, for example in very disturbed patients with eating disorders (Claire Tanner, personal communication). It should be noted that there may be as many ways of describing these role enactments through contextual reformulation as there are 'difficult patients' and therapists doing them. The two examples below will show relatively straightforward staff team splits and enactments.

## EXAMPLES OF SIMPLE CONTEXTUAL REFORMULATIONS

### Case example: Brenda (Therapist IK)

A 'difficult' patient on a palliative care unit.

This reformulation was constructed on the basis of an initial diagram of a revised 'subjective self' done with a patient on a palliative care unit, followed by discussion in a team meeting of how they were reacting to what they mostly

perceived as a 'difficult' patient. Figure 11.1 shows a simple, basic split between collective 'sympathetic' and 'difficult' aspects of both the patient's subjective states and role enactments and those of the team.

Brenda was a middle-aged woman with an advanced, inoperable tumour who had been recently referred to the unit. She confided to the therapist, who of course had the luxury of time to sit down with her, that she was angry about how this referral had happened without any consultation with her, but said that she was afraid to stir things up by saying so. She did not know the new team and was now reluctant to take her medication. She was also angry that she was no longer allowed to smoke on the ward and had to be accompanied somewhere outside, if staff were available to do so. She felt bad about being a burden to others and felt frequently hopeless and suicidal. She tended to feel she 'ought' to keep these feelings to herself but sometimes they 'burst out' at her husband, which made her feel even worse. A few staff were sympathetic to her, but on the whole the team were fed up and irritated with her and could not understand why she was behaving the way she was when they were trying to help. The result of the discussion and the construction with the staff team of the contextual reformulation was firstly of astonishment and genuine upset at seeing what the patient felt. There was also a general feeling of relief that they could understand better what was going on and that it was not directly their fault for doing a bad job. This was clearly a concern for many of the nurses. It also led to the decision that the consultant should take some time to explain why she had been transferred and the nurses decided to fix a time each day to explore and encourage ventilation of how she was feeling.

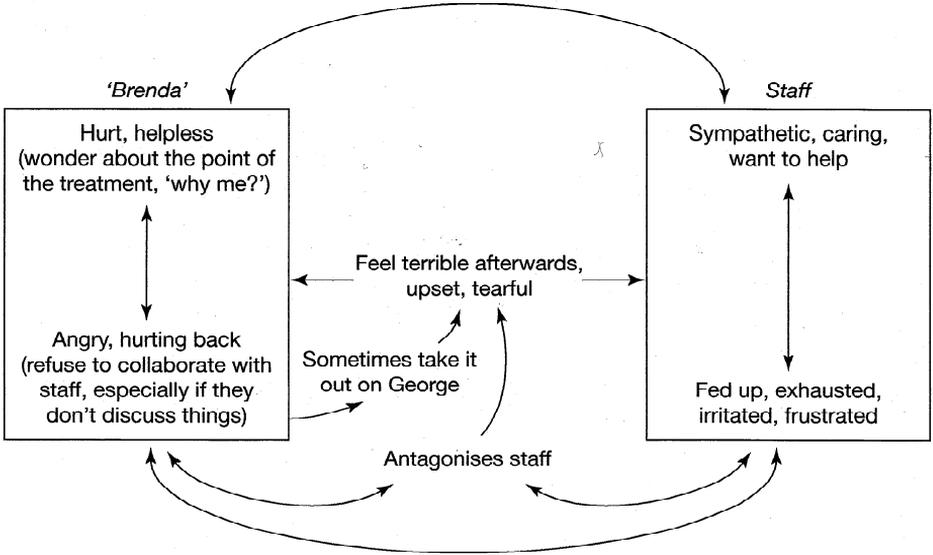


Figure 11.1 Simple contextual reformulation for Brenda developed from the patient's own SDR (left). Team reactions are described in terms of a basic split

Arguably, some of this 'should' have been routine practice on such a unit, but militating against this is the extreme pressure of time on staff, in addition to a residual culture of *doing things to or for* patients rather than *being with* them. In addition, junior staff were neither trained, encouraged nor supported to explore psychological issues with patients. Finally, neither staff nor patient were aware of these processes and they could not have been accessed or understood without some structured exploration. These issues can be explored to some extent in routine staff support meetings, but all too often these discussions are piecemeal and complicated by internal, staff team enactments. In particular, without the top-down, global understanding offered by a diagrammatic reformulation, staff are often left not knowing how things interconnect or how best to proceed. In this particular instance the intervention was identified in a case review as being of considerable usefulness to both patient and team. In addition, Brenda's husband reported that things had improved considerably and that, in particular, she seemed able to talk more openly about 'things' and that this had also helped the family overall.

#### **Case example: Paula (Therapist IK)**

A 'difficult' patient on a forensic secure unit; this case also illustrates some general points about the treatment of anxiety-related disorders.

This reformulation was constructed as a consequence of a request from a forensic team on a secure unit for help in managing a 'difficult' female patient. Paula was a young woman of about 30 with a diagnosis of personality disorder and mixed anxiety and depressive disorder. She had been causing considerable chaos and anxiety in hospital where she had been for several months following transfer from prison. The 'difficult' behaviour had consisted in her becoming acutely anxious, panicky and at times 'aggressive', seeking help by rushing around screaming and attacking staff and occasionally resorting to self-harming behaviour such as banging her head on walls. This behaviour caused considerable concern as well as frustration and irritation among staff. This had resulted in several stays on the acute locked ward where she usually calmed down after a few days before being returned to a general ward where, however, the pattern of behaviour would be repeated. Paula's most recent admission to prison had been due to similar behaviour when she assaulted a passer-by on the street because of feeling 'panicky', an act which had broken the conditions of her probation. Her previous admission, which had resulted in her spending a year in prison, had occurred after she had attacked her husband with a knife although this had not resulted in serious injury. It was difficult to determine exactly why she had done this but it appeared in her account to have been because, for once, he had been unable to contain her panicky feelings himself and had worsened her feelings to such an uncontrollable state that she had 'gone for him'. This she bitterly regretted and she was still clearly very fond of

him. The issue of the future of her marriage and her anxieties about whether she might ever harm him again were major sources of concern to her at the time of assessment.

By the time of the CAT-based assessment, her mood and behaviour had improved somewhat, although the team were still very worried about further relapses and about the question of long-term management. The staff request was for a consultation rather than for individual therapy. Paula did agree, however, to some exploratory sessions with the therapist with a view to reformulating both her own problems and the systemic 'difficulty', if possible in conjunction with the team. She was now having regular sessions with the team psychologist on the management of her panicky and anxious feelings, as well as regular art therapy sessions where she was able to express some of her more troubled emotions. These, and the more containing atmosphere of the secure unit, all contributed to calming her and making her feel, as she put it, 'safer'. Nonetheless, throughout the initial few sessions she kept asking whether things would eventually be 'OK' and whether she would manage again at home and when that would be. It was very hard to conduct these sessions due to these constant interruptions and for a while it appeared that she might not be able to cooperate with the work at all because of her levels of anxiety. Despite this, and partly through the obviously calming and containing process of sitting down to draw a diagrammatic reformulation, it began to be possible to develop a picture of her background and of the events which had led up to her being on a forensic unit.

Her background included an upbringing in a harsh, working class environment where she was afraid of a violent father (who in addition may have abused her) and a mother whom she described as cold and distant. She herself always felt she 'ought' to cope with things on her own despite nearly always feeling anxious and inadequate about both family life and school. Nonetheless she did complete school and worked for many years as a secretary. She always found relationships with men difficult and her husband had been her first serious boyfriend. Significantly, it appeared, her feelings of anxiety had worsened after they had finally become married several years previously at which time, she said, she had experienced acutely anxious feelings about whether she was 'up to' marriage and possibly having children. However, she had also helped him considerably given that he was not sophisticated (she looked after all the bills and correspondence), and he in turn was a great support when she felt bad and panicky. Nonetheless there appeared to be a part of her (a dialogic 'voice') which 'told' her she ought to cope and keep really difficult feelings to herself. Paula had had an experience of analytically based psychotherapy previously when she had, as she put it, 'gone through all that childhood stuff' and which had been of some help. However, she felt it had not resulted in her difficult feelings or insecurities going away. The picture that finally emerged is depicted diagrammatically in Figure 11.2 and was described in a reformulation letter (not shown) which rehearsed her story, problems and several key target problem procedures (TPPs).

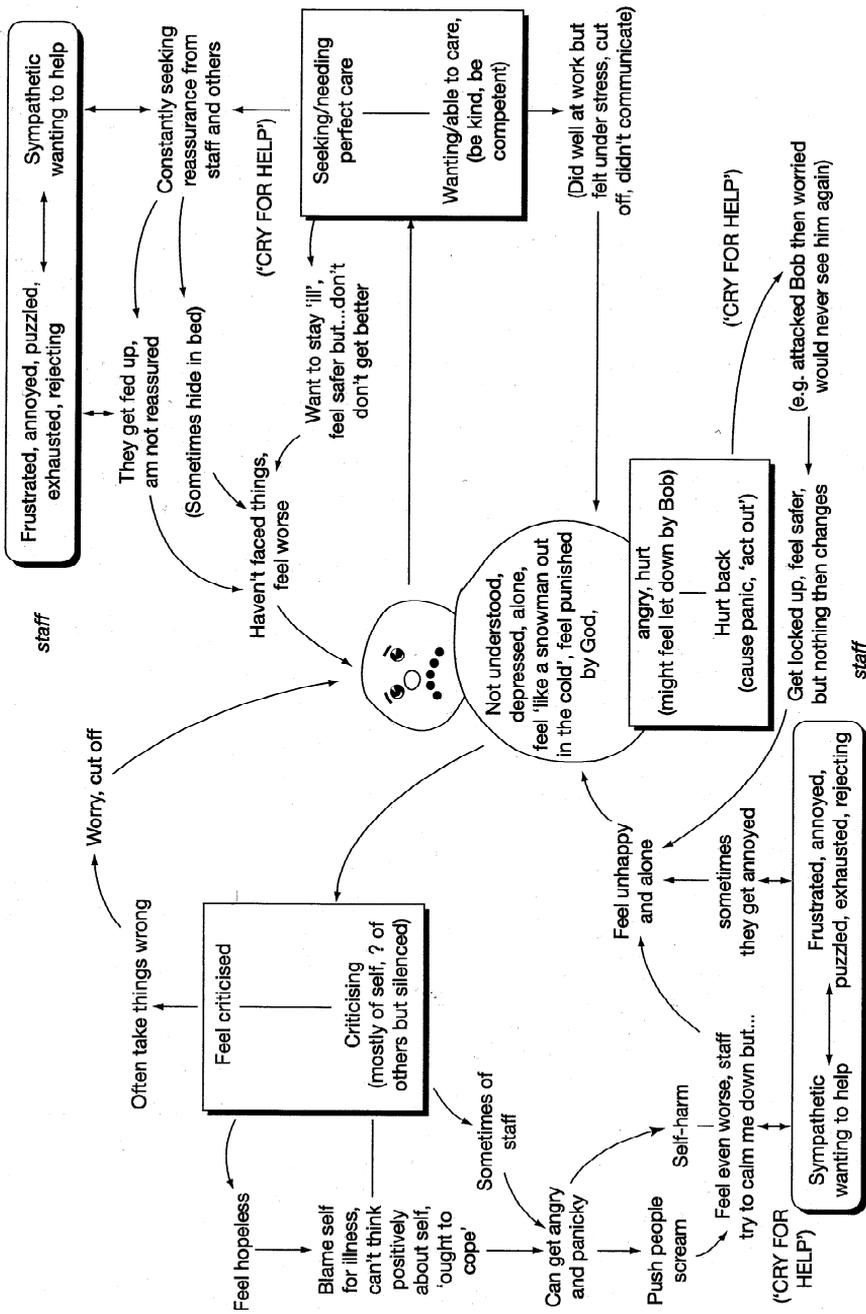


Figure 11.2 Contextual reformulation for Paula showing her own SDR centrally. Staff reactions to her role enactments are mapped collectively at the top and bottom

The contextual reformulation (Figure 11.2) initially centred around Paula's very moving perception of herself as a 'frozen snowman' all alone outside and looking in at everyone else. The initial diagram also depicted her key reciprocal role procedures (RRPs). She herself was able to describe staff reactions to her behaviours and these were confirmed and amplified by discussion with the staff team. These reactions centred around two essentially similar, split sets of role enactments which were mapped on at the top and bottom of the diagram. This appeared to be both illuminating and a relief to members of the staff team who were able to consider their reactions to her and plan future management using these understandings. Interestingly, she was by now having parallel discussions with both her psychologist and art therapist about her 'ought' voice and where it came from and what to do with it. She was also able to consider the idea that she might try to communicate her difficult feelings to others (for example staff) instead of acting on them, and see what happened. The index incident of her attack on husband was explored in the light of the reciprocal role enactments described on the diagram. It appeared that the critical event had been when he suddenly 'jumped', in her perception, from being a helpful, secure person into something like an abuser (with its probable historic antecedents). At this point she dissociated and 'state-shifted' into a *vengeful/attacking* role from a *fearful/abused* role which resulted in her 'going for him'. This, of course, she immediately regretted but had not been able to control. The enactment of similar RRP's has previously been well documented by CAT therapists working with victims of abuse (Clarke and Llewelyn, 1994; Pollock, 1996).

This case shows how attempts to work with symptoms of panic and anxiety may remain relatively ineffective unless the reciprocal role procedures underlying their generation and enactment are addressed and worked with. Wells (1999), working within another conceptual framework, has discussed the need to work with the 'meta-cognitions' underlying such symptoms. Our reservations about the limitations of this approach are discussed in Chapter 9. Paula reported that working on her TPPs had also been of considerable help to her in recognising, understanding and revising her maladaptive procedures. Overall, it appeared that the staff team had been helped by discussion of the descriptions of role enactments in the contextual reformulation. However, they also wanted explicit 'aims' for themselves in terms of what to do if certain behaviours did occur. The advice given was that they should try to recognise where they were on the diagram and what they were enacting, so as to work at not provoking and colluding with Paula's enactments of her maladaptive behaviours. They were also advised to help the patient likewise to recognise where she was on the diagram.

This case represents a further example of *using* CAT as a consultation tool to a team carrying responsibility for continuing care and treatment of the patient. The work of the therapist in this consultation role was to provide a reformulation to be discussed and handed back to a hard-pressed team and to the patient for further use.

## USES AND APPLICATIONS OF CONTEXTUAL APPROACHES TO THE 'DIFFICULT' PATIENT

Work of this sort with the 'difficult' patient, comprising both support, containment and education, may be an application of CAT of some usefulness. For example, one district psychology service in the UK (Dunn and Parry, 1997, and Mary Dunn, personal communication) has developed a consultative service which works with patients suffering from personality disorders. The team routinely uses CAT for assessing and describing relationship processes. They see themselves as employed to identify, name and then step out of the process, handing back treatment to the original team. Usual approaches to risk management can be counter-productive with this client group and they have found that a strong multidisciplinary team with a formulated rationale for its actions can paradoxically reduce risk by taking risk. An example of this is the situation where a client's suicide attempts in hospital seem to escalate as the staff increase their levels of observation and where the client is safer for being discharged. The use of this model has made demands on staff who must ask themselves searching questions about their own role in the relationship. It is seen as turning a traditional medical model on its head to suggest that changes we make in ourselves as health professionals may be important for the client or patient. It is recognised that many of these patients will have had extreme experiences of abuse or deprivation in their early years and may be able to induce similar or reciprocal enactments from everybody they meet. This team, using these contextual approaches, has placed a high priority on changing this experience for these patients within the mental health service.

Experience is still accruing in the use of such techniques of brief consultative interventions, but naturalistic studies completed so far suggest they may be effective tools for use in a range of settings and problems.

### FURTHER READING

Main's (1957) classic paper 'The Ailment' describing the difficulties encountered in working with the 'special' patient is still well worth reading, as is Menzies-Lyth's (1959) classic work on anxiety in institutions. A thoughtful account of systemic difficulties in mental health services from an attachment theory perspective is given by Adshead (1998). The systemic application of CAT to organisational pathology was first described by Walsh (1996) and subsequent clinical applications by Dunn and Parry (1997) and Kerr (1999).