A Cognitive-behavioural approach to ‘heartsink’ patients

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Aims of lecture

- Improve understanding of the nature of ‘heartsink’
- Overview of basic principles of CBT and Cognitive-Behavioural Model (CBM)
- Using CBT to cope with heartsink experiences

What is ‘heartsink’?

- Examples

Patient groups commonly described as ‘heartsink’ - 1

- Violent, aggressive, verbally abusive
- Unresolved repeated complaints / presentations
- Multiple complaints - ‘shopping list'
- Patients with psychosomatic complaints
- Complaining, never satisfied
- Manipulative, lying
- ‘Everything hurts' / ‘total body pain’
- Talkative, rambling – ‘difficult historians’

Patient groups commonly described as ‘heartsink’ - 2

- High levels of anxiety (especially about health)
- Doctor perceives there to be no ‘genuine’ problem
- Demanding, lack of respect for doctor’s knowledge / experience
- Litigious
- Angry with the doctor, uncooperative
- Difficult psychiatric patients
- Drug addicts

‘Heartsink’ patients or ‘heartsink doctors’?

- ‘Heartsink’ is a subjective experience of the *clinician*
- Variety of negative emotional responses to particular patients or situations
- e.g. feelings of anxiety, anger, guilt, hatred, fed up, low or depressed

Factors associated with higher numbers of perceived ‘heartsink’ patients

- Inexperienced doctors
- Greater perceived workload
- Lower job satisfaction
- Lack of training in communication skills
- Personal emotional problems (e.g. underlying depression / anxiety)

Clinician factors that increase perception of ‘heartsink’

- Experiencing personal anxiety
- ‘Pressured’ type of personality
- Overly critical or judgmental character
- Needing to be constantly liked by patients
- Excessively defensive personality
- Being overly nice

Cognitive-behavioural therapy (CBT): background

- Highly evidence-based treatment for wide variety of psychological and emotional disorders including:
  - Depression (as effective as antidepressants and lower rate of long-term relapse)
  - Generalised anxiety / Panic disorder
  - Social phobia
  - Obsessive-compulsive disorder
  - Health anxiety (hypochondriasis) / Medically unexplained symptoms

CBT for physical disorders

- Also evidence of benefit in some ‘physical’ disorders:
  - Diabetes (improves mood and diabetic control)
  - Chronic pain
  - Irritable bowel syndrome and other functional disorders
  - Insomnia
  - Epilepsy

Using a CBT approach to problems

- Aim to *identify* and then *evaluate* individual reactions to specific situations
- Identify and change unhelpful thoughts, beliefs and behaviours that contribute to problems
- Enables *choices* about helpful and appropriate ways to react in specific circumstances

Basic principle of CBT

- How people *think* in specific situations affects how they *feel* (emotionally and physically) and how they *behave*

Different thoughts cause differing feelings and behaviour….

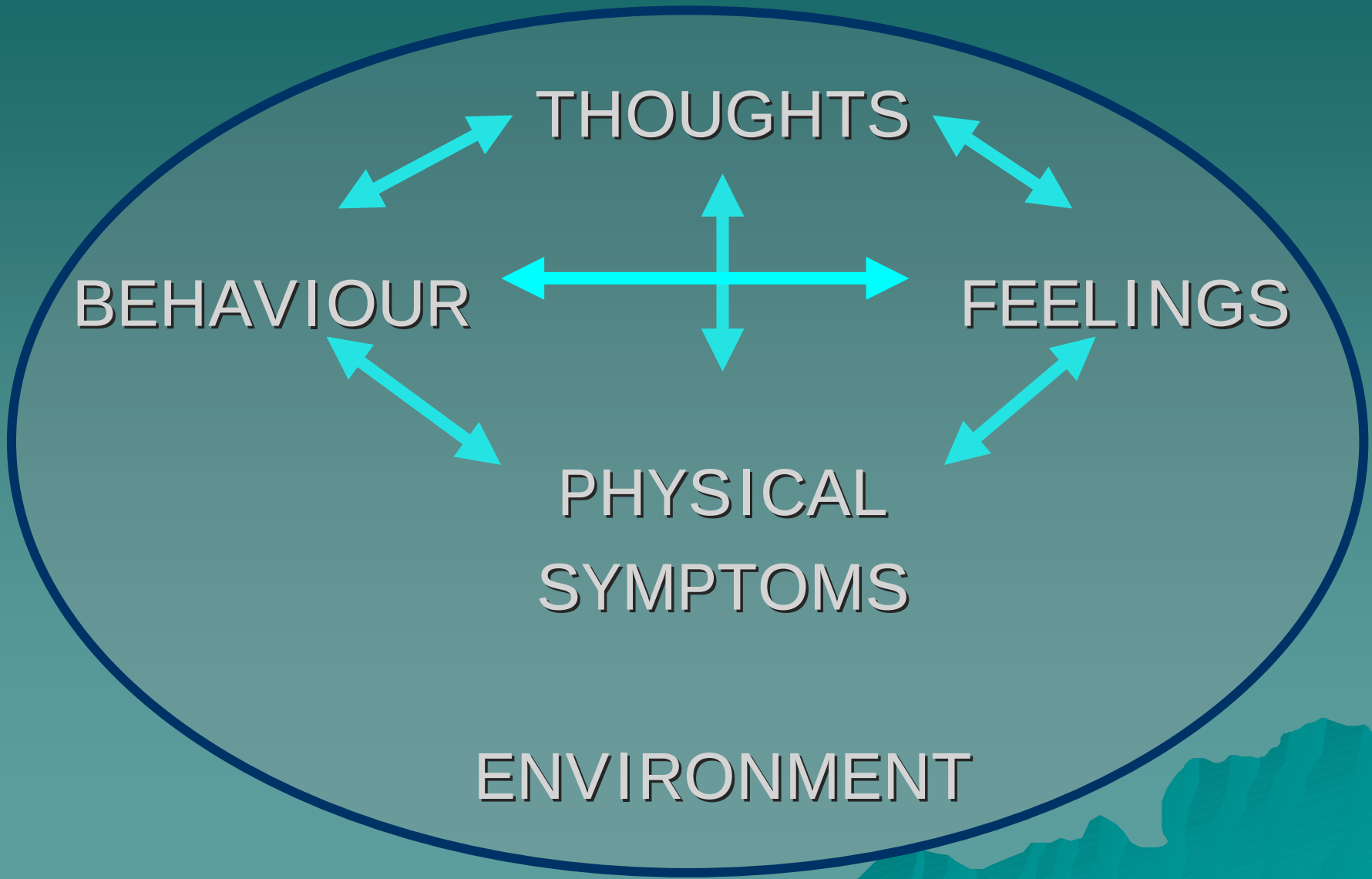
Consider the following situation:

You have cooked dinner for a friend, who is usually very reliable. An hour after she was due to arrive, there is still no sign and you have received no phone call...

Different thoughts cause differing feelings and behaviour….

Thoughts	*"How dare she do this to me! She is so inconsiderate and rude!"*	*"She probably didn't want to come because she doesn't really like me."*	*"What if she's had an accident? She could be seriously hurt."*	*"I expect she's stuck in traffic. At least I have extra time to prepare dinner"*
Feelings	Anger	Depression	Anxiety	Relieved
Possible Behaviour	Tell her off or act chilly when she arrives	Withdraw from people and stop asking them over	Phone local hospitals	Continue preparing dinner

The ‘Cognitive-Behavioural Model’ (CBM)



CBT approach to ‘heartsink’

- Need to understand our own, individual reactions to ‘difficult’ situations
- 2 clinicians may find the same patient stressful for different reasons
- Aim for ‘coping’ not ‘cure’
- Expecting patients to change can leave us ‘stuck’ with no way to improve things

Why invest time in looking at our own reactions?

- May be the *only* way to feel better in relation to certain patients who are unlikely to change
- Improves clinical skills – strong negative emotion unlikely to promote effective clinical judgements
- Important to understand how we may *contribute* to problems with 'difficult' patients
- If negative reactions persist or get out of control we are at greater risk of stress, burnout or depression

Case Example

Dr W arrives for a busy morning surgery. She is 10 mins late because of traffic delays and she already feels flustered and irritable.

When she looks at the list of patients for the surgery she notices that Mrs C is booked in for an appointment at 10am....

Case example 2

Mrs C is 50 years old and presents regularly to the surgery with multiple, changing symptoms.

She has been investigated on a number of occasions and has been diagnosed with non-organic chest pain but has never been found to have any serious, organic disease.

She is anxious and talkative and Dr W finds it difficult to know how to help her.

Case example - 3

Thoughts

- *"Oh no, it's Mrs C!"*
- *"She will make me late for the rest of the surgery"*
- *"What does she want this time? There is nothing I can do to help this woman"*
- *"There's nothing wrong with her anyway! It's just wasting my time"*
- *"But what if there is really something serious wrong with her this time and I miss it?"*
- *"I am so fed up with this constantly busy surgery"*

Case example - 4

Feelings

- Low mood
- Anxious and stressed

Case example - 5

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Behaviour

- Try to rush through the surgery
- Worrying about seeing Mrs C – not fully concentrating on other patients
- When Mrs C comes in – try to hurry through seeing her: not fully listening, irritable and less empathic than usual, quick to make a referral when she complains of a new symptom

Identifying ‘heartsink’ reactions

- Thoughts:

  What goes through my mind when I am faced by this patient?

  What is the most stressful part of the situation?

- Feelings

  How do I feel when I see this patient?

  What are the strongest emotions?

- Behaviour

  How do I react to this patient?

  Do I behave differently with them than others?

Questioning ‘unhelpful thoughts’

- *What is the* evidence *for this thought / belief? Is there any evidence against it?*
- *Is it logical or realistic? Is there another way to view the situation?*
- *Is it helping me to do my job?*
- *What are the pros and cons of thinking this way?*
- *What advice would I give to someone else in this situation?*

Overcoming unhelpful thinking - 1

Thought / associated feelings	More helpful alternative
"Because I am running late in surgery, the rest of the day will be a disaster as well"	

Overcoming unhelpful thinking - 2

Thought / associated feelings	**More helpful alternative**
"Because I am running late in surgery, the rest of the day will be a disaster as well" *Anxiety* *Depressed*	I *am* running late, which is stressful and frustrating. But, thinking how everything else will be a disaster just makes me feel even *worse*! It is not possible to predict what will happen later today but it may not be all bad! I have survived busy days before – it's not a *complete disaster* (***black and white thinking***)

Overcoming unhelpful thinking

Overcoming unhelpful thinking - 4

Thought / associated feelings	More helpful alternative
"I should be able to help patients otherwise I've failed, I'm not a good doctor" Depressed Low Anxious	There is lots of evidence that I am a 'good enough' doctor. No one can be perfect! It is not possible to 'cure' everyone – that doesn't mean I am a bad doctor. There may be other ways to help this patient – e.g. I may be able to help her learn to cope better with her symptoms. At the very least I can offer some empathy and support.

Overcoming unhelpful thinking - 5

Thought / associated feelings	More helpful alternative
"What if there is really something wrong with her this time and I miss it? *I could make a major mistake and she would sue me!"*	

Overcoming unhelpful thinking - 6

Thought / associated feelings	More helpful alternative
"What if there is really something wrong with her this time and I miss it? I could make a major mistake and she would sue me!" Anxiety	It is possible that Mrs C does have something genuinely wrong. This is true for every patient I see. However, worrying about it does not help me find out. No one can be 100% certain – I just have to make the clinical best judgement I can.

Overcoming unhelpful thinking - 7

Thought / associated feelings	More helpful alternative
"There's nothing wrong with her anyway! *Seeing her is just wasting my time"*	

Overcoming unhelpful thinking - 8

Thought / associated feelings	More helpful alternative
"There's nothing wrong with her anyway! *Seeing her is just wasting my time"* *Anger*	Thinking this way is likely to make *me* feel frustrated and irritable. Whether I like it or not, seeing patients like Mrs C is part of my clinical workload, so it may be easier to simply accept this and cope with it as best I can. She is experiencing genuine physical symptoms which she is terrified of – if I try to understand her perspective it may be easier to feel less frustrated and annoyed.

Overcoming unhelpful thinking - 9

Thought / associated feelings	More helpful alternative
"It's the patient's fault I feel so stressed and fed up. *She shouldn't behave like that"*	

Overcoming unhelpful thinking - 10

Thought / associated feelings	**More helpful alternative**
"It's the patient's fault I feel so stressed and fed up. She shouldn't behave like that" Anger	The patient is demanding and difficult because she lacks more helpful coping strategies for problems. ***How I feel depends on my own expectations of myself and others***. Blaming her for my stress will make our relationship more difficult and make me feel worse when I see her. Maybe I can just accept that she is a difficult person and worry less about it!

Beliefs that may *worsen* problems with ‘heartsink’ patients

- *“I can’t get her out of the room – she would think I am rude if I ask her to leave...”*
- *“The only way to deal with these patients is not to listen and just get rid of them quickly...”*
- *“This ‘demanding’ patient does not respect me...”*
- *“I had better do a few more tests just to be sure it isn’t anything serious after all...”*

New cognitive approaches

- ‘Flexible’ rather than ‘absolutist’ (black and white) thinking
  - Rational, ‘evidence-based’ thinking (not simply ‘positive thinking’)
  - Compassionate thinking
- Acceptance of imperfection in self and others
- Being ‘good enough’

New cognitive approaches - 2

- Maintain focus on *long-term* as well as *short-term* outcomes / goals
- Learning to accept uncertainty in life (reduces anxiety)
- Put negative experiences into context:

  "How bad is this really?"

  Use of 'continua' line

  Keep a sense of humour

Principles of changing unhelpful behaviour

- Behavioural change often the easiest point to ‘break’ in the vicious cycles of negative thoughts and feelings
- Changes can be made even without altering underlying thoughts / beliefs
- Behaving ‘as if...’

Changing clinicians' unhelpful behaviour - 1

Behaviour	Potentially unhelpful impact on patient	More helpful alternative
Not listening closely, poor eye contact, focus on other things	Patient assumes you haven't heard and *repeats information again* (talks more!) Patient feels aggrieved – relationship deteriorates (increases risk of litigation) Risk missing important clinical information – make mistakes	Listen *more closely* and give full attention. Make patient aware you are interested and prepared to give them your time Try to engage the patient in trying to *help you* to help them

Changing clinicians' unhelpful behaviour - 2

Behaviour	Potentially unhelpful impact on patient	More helpful alternative
Over-investigation or unnecessary referrals to 'reduce anxiety' (of both doctor and patient)	*Increases* patient's anxiety about their symptoms *"The doctor must think it's serious…"* More likely to return for further tests / referral *"The doctor thinks you must always do tests whenever you feel the pain…"*	Investigation and referrals *when clinically indicated* not simply to 'buy time' or to 'reduce anxiety' (managing clinical risk / uncertainty) Discuss patients' anxiety about symptoms as well as symptoms themselves (use CBM to link psychological and physical factors)

Behavioural strategies for coping with time limitations

- Allow patients to speak for up to 90s without interruption at start of consultation
- Discuss time limitations *in advance* so patient is prepared
- Negotiate an agenda (i.e. a purpose for the discussion) by asking patient to prioritise their *most important* issues and openly explaining your own agenda items
- Explain need for focused (but open) questions

  "There is limited time today and I want to make the most use of it as possible"
- Or for interruption...

  "I *may sometimes need to stop you to make sure I'm getting all the information to help me to treat you most effectively. Is that OK?*"

Coping with time limitations - 2

- Avoid lengthy debates or arguments with patients e.g. about the cause of physical symptoms. Simply empathise with their view ('agree to differ') and move onto what options are available
- Use broken record technique
- Set boundaries (for yourself and patients) for what can realistically be achieved within a single appointment
- Plan consultations in advance for frequent attenders (ideally with *same clinician)*
- Give *positive explanations* for benign symptoms

Using the CBM with patients

- Improve management of emotional disorders and psychological aspects of physical disease
- Greater understanding / empathy for patients associated with increased *doctor satisfaction* from consultations
- May improve ‘compliance’ with treatment
- Can be interesting and enjoyable

Seeking help

- Self-care: monitoring our own emotional responses
- Maintain healthy work / life balance
- Knowing when to seek help:
  - Peer support / discussion
  - Mentors / clinical supervisors
  - Register with a GP
  - Occupational health
  - Other confidential organisations

Seeking help - 2

- **BMA telephone counselling service** (24h service)
  08459 200169
- **National counselling service for sick doctors**
  www.ncssd.org.uk 0870 321 0642
- **Doctor support line anonymous help service**
  www.doctorssupport.org 0870 765 0001
- **Doctors support network for mental illness**
  www.dsn.org.uk 0870 3210642
- **Sick doctor's trust for drug and alcohol problems**
  01252 345163
- **BABCP** www.babcp.com
- **Samaritans**
  08457 909090

Other resources – CBT training

- BABCP: www.babcp.com
- 'The 10-minute CBT handbook for primary care' – Scion Publications (2006)
- Contact details: cbm.training@gmail.com

Summary

- Heartsink responses represent clinician's own emotional reactions to specific patients
- Reflect specific underlying beliefs and thoughts about ourselves and others
- Use CBM to identify and 'reframe' any unhelpful thoughts and change behaviour
- Improves clinicians' feelings / experience of 'difficult' consultations and improve clinical management
- CBM a useful tool to understand different aspects of patients' problems (psychological, emotional, physical and environmental)