Dynamic Chiropractic

DOCTOR-PATIENT

Patient Personality and Clinical Compliance (Pt. 2)

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Inconsistent patient compliance is an ongoing issue in many practices. Many patients enter the office, ask for help, seem ready to proceed, and then become an impediment to the process.

Much of this problem is personality-based. Some patients have personality types and traits that are hard to manage; personalities that create obstacles and result in patients being their own worst enemies.

These truths are the basis for this series. Doctors must be able to recognize challenging personality types and handle the circumstances they create. Prompts for patient communications are incorporated into the discussion of each personality.

In part 1 [May issue] of this series, I described detail-oriented and skeptical patients. Now let's discuss patients in denial and anxious-depressed patients.

The Patient in Denial

Two of the most challenging topics to discuss with patients are being overweight and needing some level of mental health care. Many overweight patients know they are too heavy, but deny it is a factor in their condition. The same occurs for many patients with mental health issues.

Overweight patients will often state, "I was overweight long before my back began to hurt." In this situation, I compare a bathtub to the human body frame.

The comparison: A bathtub holds a specific amount of water. But once the tub reaches its total capacity, something must give. The tub overflows. Like the tub, your frame can only hold a specific amount; once total capacity is reached, something must give. Joints and muscles are injured, and pain begins or is prolonged. There is an interval between empty and full, average weight and overweight, in which everything seems fine.

With the tub example, turning the water off stops the overflow. This helps, but leaves the tub at total capacity. Draining some water is a sounder option. But if the amount of water is not significant, the tub is still near the point of overflowing. Draining a substantial amount of water is the best option.

For the body frame, losing weight can relieve pain. But if the weight is not significant, the body's frame is still near the breaking point and the return of pain. Losing a substantial amount of weight leads to better results.

For patients with mental health issues, denial is common.In some cases, these patients begin the history process by describing how other providers said their condition was "all in their head." They might also start by looking directly at you and saying, "Don't tell me this is in my head."

If you determine one or more physical conditions exist, but mental issues are a concern, a

description of the patient's physical findings and diagnosis must occur before discussing mental health issues. Always assure the patient that a physical problem has been identified first.

Once this is accomplished, it allows you to segue into a conversation of how the degree of pain, missed work or home life, a lack of family support, failed treatments, etc., have taken a toll on the patient's mental health. The mental health issue then cycles around to perpetuate the physical problem.

The cycle must be broken through a combination of physical and mental assistance. You should make the referral after these procedures.

Patients experiencing actual physical problems complicated by mental health issues are more common than patients experiencing physical symptoms that originate purely in their heads. However, patients with purely mental issues are encountered in chiropractic practice. When confronted with this situation, I tell these patients I do not know what is wrong. I continue by explaining it may be because I am unfamiliar with the condition or it is something outside my expertise.

I tell them I cannot help them. I conclude the conversation by remarking that the lack of help in their case so far is taking a toll on them. I strongly recommend they seek counseling to help with their struggles, then offer to make the referral.

This explanation leaves the possibility open that I did not identify a physical pathology that does exist. The description is essential for two reasons: preventing the assumption that I am a perfect diagnostician or a mental health expert.

I never tell a patient that their problems are all in their head. Let a mental health provider make that diagnosis.

The Anxious-Depressed Patient

The number of new patients who check the box for anxiety and depression on my entry forms is substantial. These patients also reveal a history of utilizing prescription medications for anxiety and depression. Other doctors I work with tell me they see the same trend in their practices.

Like detail-oriented patients (part 1), anxious and depressed patients focus on every slight twinge and symptom. Doing so leads to further anxiety and a lack of focus on the positive results of care. The patient could be 80 percent improved, yet be obsessed with the remaining 20 percent.

While denial patients refuse to believe their mental health is a factor in their condition, anxious patients freely acknowledge their mental issues. Many have had or are seeing a provider for their troubles.

A critical factor for denial and anxious patients is their healing rate. Both heal slower, have more setbacks and encounter more recurrences.

Like denial patients, you must describe physical findings and diagnoses to anxious patients before discussing mental health issues. You also must assure these patients by confirming a physical problem before referring to known mental health issues.

Once this is accomplished, it allows you to segue into a conversation of how the degree of pain, missed work or home life, a lack of family support, failed treatments, etc., have taken a toll on the patient's mental health. You should then ask to make a referral.

A Warning With These Patients

A warning about patients in denial and anxious-depressed patients is necessary. It is good to ask these patients if they have had previous thoughts or have current thoughts of suicide. These situations require immediate referral, even without the patient's permission. Referral may need to be to law enforcement.

Author's Note: I will conclude this three-part series on patient personality traits and their impact on the clinical encounter by addressing one-visit-wonder and best-buddy patients [July issue].

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