# North Carolina Society of Gastroenterology 2026 Annual Meeting

# Managing Challenging Patients: Clinical and Psychological Insights

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Joint Providership

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# Objectives:

| | |
|---|---|
| Understand | Understand Psychological Factors Influencing Patient Behavior |
| Apply | Apply evidence-based communication and behavioral strategies |
| Identify | Identify Interdisciplinary Interventions for Optimal GI Care |
| Case | Case Presentation: Psychological Insights |

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# WHY "DIFFICULT" PATIENTS MATTER IN GI PRACTICE SETTINGS

Impact patient outcomes

Provider stress and burnout

Cost implications

# UNDERSTANDING OUR DIFFICULT PATIENTS: PSYCHOLOGICAL DRIVERS

**Example scenarios:**

- The **non-compliant patient** who ignores medical advice and frequently misses appointments
  - *Has low health literacy, ongoing and persistent GI symptoms and needs support navigating the medical system*
- The **demanding/entitled** patient who frequently sends EPIC messages for prescription refills, yet has not been seen in clinic in over 12 months
  - *Has a mistrust of providers due to past trauma*
- The **angry** patient who displays verbally abusive behavior
  - *Has an untreated depressive disorder and is not set up with behavioral health*
- The patient who has **vague physical complaints**, but normal tests
  - *Has GI-specific anxiety, catastrophic thinking, which has not been addressed*
- The "**high-utilizer**" who frequently seeks medical attention
  - *Is seeking re-assurance, and has a low tolerance for uncertainty*

There's usually "more" to the story…

## A Cohort Study Assessing Difficult Patient Encounters in a Walk-In Primary Care Clinic, Predictors and Outcomes

*Sherri A. Hinchey, MD MPH*[1] *and Jeffrey L. Jackson, MD MPH*[2,3]

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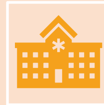

Among 750 subjects at an internal medicine acute walk-in clinic at Walter Reed Army Medical Center, 133 (17.8%) were perceived as difficult

"Difficult" patients were less likely to fully trust, or be fully satisfied with their clinician, and were more likely to have worsening symptoms at 2 weeks post-visit

Patients involved in "difficult encounters" had more than five symptoms, endorsed recent stress, and had a depressive or anxiety disorder



Hinchey & Jackson (2011)

# FROM THE CLINICIAN'S LENS

- To understand a difficult patient, we must understand the dynamics that make the encounter challenging

- Difficulty arises from complex interactions between patients and providers, clinician factors, and situational stressors rather from the patient alone

  - The **demanding/entitled** patient who frequently sends EPIC messages for prescription refills, yet has not been seen in clinic in over 12 months
    - *triggers feelings of frustration in the clinician*

  - The patient who has **vague physical complaints**, but normal tests
    - *triggers feelings of inadequacy in the clinician*

  - The "**high-utilizer**" who frequently seeks medical attention
    - *can lead to clinician burnout*

# SO, HOW DO WE EFFECTIVELY BUILD RELATIONSHIPS WITH PATIENTS AND MANAGE THE “DIFFICULT” PATIENT?

**Patient-provider communication is essential to managing the difficult patient in GI practice settings as these strategies aim to enhance the therapeutic relationship**

**Table 5.** Recommendations for Optimizing the Patient–Provider Relationship[3,4,7]

| Recommendation | Examples |
|---|---|
| Listen actively | Listen without interrupting, focus on what is said and construct questions based on what you have heard |
| Understand the patient's agenda | Several questions can elicit the patient's agenda:<br>What brought you here today?<br>What do you think you have?<br>What worries, or concerns do you have?<br>What do you feel I can do for you? |
| Empathize | Empathy involves seeing the patient's perspective, being nonjudgmental, understanding the patient's feelings, and communicating that understanding. An empathic statement is "I can understand how difficult it is to manage your pain." |
| Validate | Validation means you understand the patient's perspective, but you may not necessarily agree. A validating statement would be "I can see you are frustrated when people say this is due to stress, and you know it's real." |
| Set realistic goals | Chronic illness means symptom management, not cure "I understand how much you want these symptoms to go away, but you've had them for years. If we can reduce your symptoms by 30% over the next several months, would that help?" |
| Educate | Education is an iterative process:<br>Identify what the patient understands<br>Address any misunderstandings<br>Offer information consistent with the patient's frame of reference<br>Check the patient's understanding |
| Reassure | Reassurance is provided based on the available data and not prematurely. This involves identifying the patient's concerns, validating them, and responding to the specific concerns |
| Negotiate | Patient-centered care is a partnership. The physician offers choices, and the patient makes a choice. For example, the physician can suggest treatments "A" and "B," indicating the possible benefits and adverse effects. |
| Encourage patient responsibility | With chronic illness, the clinical outcome is better when the patient takes responsibility for care. Rather than say "How is your pain"? one can say, "How are you managing with your pain"? |
| Be there | One cannot always anticipate what will come up in the clinical visit; providing support and a listening ear is indispensable. |

Drossman et al., 2021

# CONSIDER CULTURE

## PATIENT VARIABLES

- **Language barriers**: use qualified interpreters, avoid medical jargon
- **Health literacy:** provide plain language, use culturally tailored materials
- **Consider cultural differences:** ask about traditional practices and integrate when safe
- **Family involvement:** include family in decisions if patient desires
- **Verbal and nonverbal communication** be mindful of eye contact, touch and personal space

## CLINICIAN VARIABLES

- **Generational differences:** older versus younger providers may have different communication styles and comfort with digital care
- **Personal beliefs:** cultural, religious, or health-related beliefs can bias recommendations and responses
- **Self-awareness:** self-reflection is important to identify and address biases, and avoid judgmental language
- **Adaptability:** important to adjust the approach to meet patient needs

# SET BOUNDARIES

It can be important to set boundaries, when patients are non-compliant, have excessive demands, present with aggressive or disrespectful behavior, or their behavior creates a significant emotional strain

1. **Define your scope:** what you do and don't do in your practice setting
   - Can help to facilitate treatment plans with patients
   - Can promote strategic scheduling and optimal referral pathways
2. **Time management:** set limits on appointment length
3. **Communication channels:** use secure, professional platforms, avoid personal contact information
4. **Behavioral expectations:** address inappropriate language or aggression calmly and firmly to de-escalate: "I understand you're frustrated about your persistent abdominal pain, but it is important that we keep this conversation respectful. If this continues, we'll have to pause the visit and reschedule the discussion."
5. **Consistency:** apply boundaries uniformly for every patient

J Clin Psychol Med Settings (2017) 24:27–36
DOI 10.1007/s10880-017-9490-2

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ORIGINAL PAPER

# Managing Difficult Patients: Roles of Psychologists in the Age of Interdisciplinary Care

William N. Robiner[1] · Megan L. Petrik[1]

Beyond patient-provider factors, another important component is the **interdisciplinary team**

- Psychologists in medical settings can play an important role in managing or co-managing difficult patients by:
  - applying skills to enhance the clinical care of these patients
  - Addressing patient concerns
  - Supporting wellness and education for other medical providers (e.g., teaching communications strategies)
  - Reduce clinician burnout by providing resources (e.g. provide interventions to address patient's difficulties, provide crisis intervention, triage, or facilitate referrals)

Robinson & Petrik, 2017

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# MOTIVATIONAL INTERVIEWING

- **One important skill psychologists teach is motivational interviewing (MI):** empathetic, collaborative, person-centered approach that can enhance patients' goals, foster motivation for health behavior change, and support self-efficacy (Rollnick et al., 2008)
- Can help patients who are resistant to change, or have a lack of awareness regarding problematic behaviors
- Core principles:
  - **Express empathy:** use reflective listening/validates feelings
  - **Develop discrepancy:** helps patients see gap between current behavior and health goals
  - **Roll with resistance:** avoid arguing, redirect resistance into discussion
  - **Support self-efficacy:** reinforce confidence in ability to make changes
    - "You've successfully made changes before- what helped you then?"

# KNOW YOUR RESOURCES

Connect patients to **social support services** (e.g., transportation, food assistance, financial assistance)

**Behavioral Health collaboration**

**GI Psychology:**

Brain-gut behavior therapies: short-term GI-focused interventions that address GI symptoms and quality of life

**Other Non-pharmacological interventions:**

- GI-focused dietary services
- Acupuncture
- Meditative movement (yoga, tai chi)

# WHEN TO REFER PATIENTS TO GI PSYCHOLOGY VERSUS BEHAVIORAL HEALTH

## GI PSYCHOLOGY

- **Brain-gut behavior therapies:** CBT, gut-directed hypnosis, disease self-management, mindfulness-based stress reduction, emotional processing and interpersonal interventions
- Addresses factors such as GI-specific hypervigilance, symptom specific anxiety, ANS arousal, visceral hypersensitivity, coping skills
- **Primary concern** is GI-related (confirmed GI diagnosis)
- GI symptoms are the main stressor (e.g., GI-specific anxiety, catastrophizing) and worsen QOL
- Stress, coping difficulties, adherence issues worsen GI condition
- Patient has food-related anxiety or an overly restrictive diet
- Patient is open and motivated
  - Example: IBS with GI-specific anxiety and hypervigilance

## BEHAVIORAL HEALTH

- Examples: CBT, DBT, EMDR, psychodynamic approaches
- **Primary concern** is a mental health disorder
- Unstable psychiatric symptoms (e.g., severe depression, PTSD, OCD)
  - Patients with more severe mental health co-morbidities don't respond as well to BGBT
- Active substance abuse
- Untreated eating disorder or BMI <17

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# WHERE TO FIND A BEHAVIORAL HEALTH PROVIDER

| | |
|---|---|
| **Where to find a GI behavioral health provider** | Rome GastroPsych directory: https://romegipsych.org |
| **Where to find a general mental health provider** | Psychology Today: https://www.psychologytoday.com/us/therapists |

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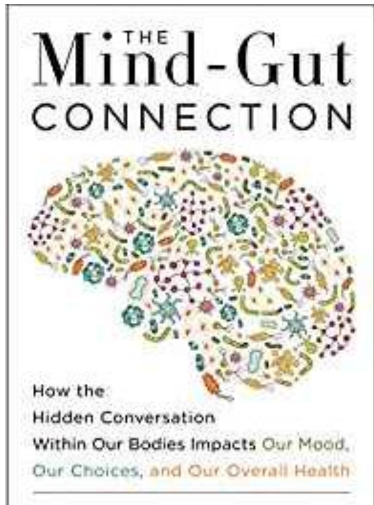


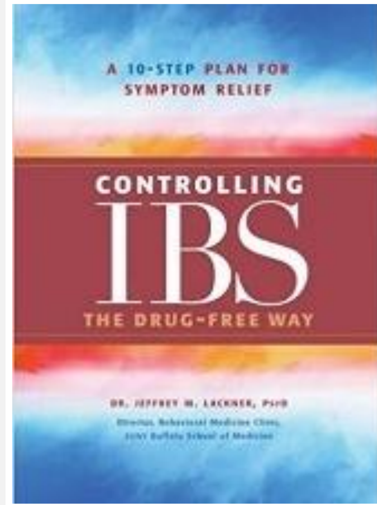


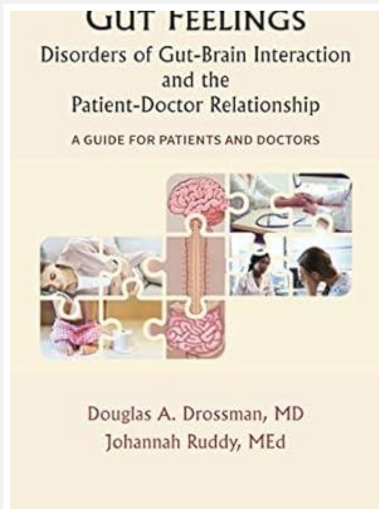


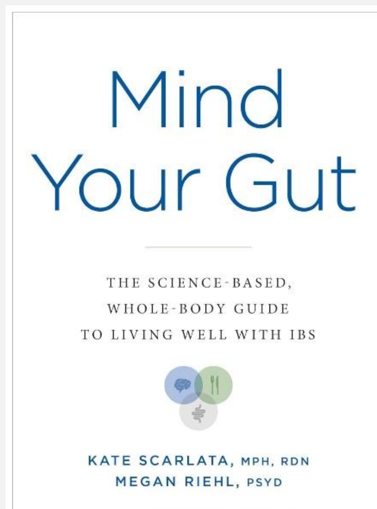


# OTHER USEFUL RESOURCES

- International Foundation for Gastrointestinal Disorders: https://www.iffgd.org
- Gastro Girl: https://gastrogirl.com
- Tuesday Night IBS: https://www.tuesdaynightibs.com/
- Rome GI Psych Section: https://theromefoundation.org/working-teams-and-committees/rome-gi-psych-committee/
- Books
- Podcasts: The Gut Health Podcast
- Digital Therapeutics: (e.g., Nerva)

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# OTHER INTERVENTIONS

GI dietician:

https://www.katescarlata.com/find-your-gi-dream-team

Acupuncture:

https://medicalacupuncture.org/Find-an-Acupuncturist/

Yoga:

https://yogatherapy.health/

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# FIND A WAY TO "LIKE" YOUR DIFFICULT PATIENT

- **Empathy, empathy, empathy:** "What might this patient be feeling right now?
- **Shift perspective:** identify strengths and positive qualities
- Separate the **person** from their behavior
- Look for **common ground**
  - Identify shared goals
  - Collaborate "We both want you to feel better"

**This will serve you well…**

# SELF-CARE FOR CLINICIANS

- Peer consultation groups
- Mindfulness and stress management strategies
- Take micro breaks
- Take care of yourself
  - Eat, exercise, sleep, hydrate
- Workload management

# CASE EXAMPLE

# PATIENT INSIGHTS

- <u>First appointment</u> to establish care
- "I will never go back because of the unprofessionalism I experienced"
- Patient was confused because the staff didn't have any of their medical records and felt that they were getting "lectured"
- "Am I expected to bring the medical records from all my doctors to my appointments?
- "I left the appointment because the doctor tried to prove a point rather than take care of me."
- Dismissed from practice

- **Patient was angry, and has demanding/entitled traits**
- Strong expectations of how care should be delivered
- Dissatisfied with care, expresses frustration and anger
- Primary themes are unmet expectations and perceived disrespect

# PATIENT ENCOUNTER FROM PERSPECTIVE OF MA

The MA greeted the patient, but only the mother responded

The MA proceeded without addressing the lack of response

Could acknowledge the patient directly in a calm, friendly tone and follow-up with empathy if they don't respond

The patient rolled their eyes and expressed anger

The MA explained the need to verify information, but repeated the same approach

Validate feelings before explaining.

Stay calm and use reassuring language

The MA attempted to reconcile "I'm sorry, we got off on the wrong foot, let's start over"

Invite collaboration "What would make this process easier for you?"

Offer choices, "Would you prefer to go over medications now or wait until the doctor comes in?" *Giving control can reduce tension

# PATIENT ENCOUNTER FROM PERSPECTIVE OF PHYSICIAN

The patient refused to answer the MA and physician's questions so he explained that without her medical records, he could not treat her if she did not answer their questions

Begin by acknowledging the patient's frustration

When she raised her voice to the physician, he asked the office manager to come into the room

Bringing the office manager too quickly can feel intimidating, try de-escalating techniques first (e.g., lower voice, use non-confrontational language)

Offer choices for the patient

Use structured communication, "I want to hear everything you have to say. Let's take turns so I can fully understand your concerns"

Patient would not let the physician speak, so the physician left the room

If you have to step out, explain why and what will happen next

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# PATIENT ENCOUNTER FROM PERSPECTIVE OF OFFICE MANAGER

- The office manager arrived when the patient was speaking loudly to Dr. Columbus.  She would not let him talk and interrupted when they tried.
  - An authoritative approach can escalate tension
  - It may help to pause, observe, and calmly introduce yourself
  - Active listening is important
  - Set, clear respectful boundaries
  - Give the patient options "Would you like to share your concern first, and then we'll talk about how to proceed?
- Patient no longer wanted to be treated by Dr. Columbus
  - Respond professionally, avoid showing frustration or judgement

# THANK YOU!

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