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The Use of DBT Skills in the Treatment of Difficult Patients in the General Hospital

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Dialectical behavior therapy (DBT) is a form of psychotherapy developed by Marsha Linehan in the 1980s to treat borderline personality disorder (1–3). Subsequent studies have found that DBT leads to less self-injury, fewer inpatient hospitalizations, and improved social adjustment in psychiatric outpatients with borderline personality disorder (4–6) and also leads to less self-injury, depression, and anxiety among psychiatric inpatients with borderline personality disorder (7).

Critical reviews (8, 9) of this literature have noted that these studies are limited by small numbers of subjects (less than 25 subjects in the active treatment groups), by the lack of a control group in the inpatient study, and by the fact that much of this research has been done by a single research group (led by Linehan). Despite these flaws, the studies do suggest that DBT can have a significant impact on psychiatric symptoms and quality of life for persons with borderline personality disorder.

DBT relies upon principles of both cognitive behavior therapy and Eastern meditative philosophy to help patients with borderline personality disorder regulate their emotions. The treatment assumes that maladaptive behaviors, including self-injury, are attempts to manage intense affect. DBT emphasizes validation of a patient's painful emotional experience and acceptance that the patient is doing the best that he or she can at that moment. DBT also emphasizes the need for change by teaching new coping skills. The skills training component of this treatment modality focuses on development of skills in four areas: mindfulness, interpersonal effectiveness, distress tolerance, and emotion regulation.

While DBT has effectively treated individuals with borderline personality disorder in psychiatric settings, it appears that specific DBT skills could be adaptable to the treatment of difficult patients in the general hospital. Such skills can be introduced to help patients on medical units cope more effectively with stressful experiences. These skills can also be taught to staff to help them regulate their own emotional reactions to difficult patients.

Here we present the hypothetical case of a patient on a medical service whose interpersonal style led to difficulties in management. Following the case vignette, we discuss how the principles of DBT and the skills that it teaches can be applied to medical patients in the general hospital.

Case report

Ms. R, a 25-year-old woman, was admitted to the hospital after an overdose of acetaminophen (25–650-mg tablets). Described as "angry, entitled, and uncooperative" in the emergency room, she was diagnosed with "depression with borderline traits" and was placed in four-point restraints. Fortunately, when she arrived on the medical service, she was calm and cooperative; she agreed to take acetylcysteine as treatment for her overdose. She and a nurse (Nurse A) laughed together at her predicament, and they shared with one another personal details of their lives. The nurse, convinced by the patient that the psychiatrist who evaluated her was too young, inexperienced, and unempathic, took Ms. R out of restraints when Ms. R assured her that she would not injure herself. Ms. R was docile and compliant with treatment during the rest of the shift.

However, when Nurse B arrived on duty, Ms. R became hostile and told Nurse B, that "the other nurse was doing a much better job of meeting my special needs." When Nurse B accidentally bumped

into the night table, knocking over some of Ms. R's belongings, Ms. R became enraged. She screamed at Nurse B and ripped out her own intravenous line. Then out of restraints, Ms. R started banging her head against the railing of the bed, creating significant abrasions. Nurse B panicked; she called the physician-on-call and hospital security. Upon their arrival, Nurse B was berated for allowing Ms. R out of restraints. When the physician began sternly telling Ms. R to stop her histrionic behaviors, a screaming match erupted, and the two began cursing at one another. Ms. R again was placed in four-point restraints, whereupon she was quiet the rest of the night. However, Ms. R did not receive her scheduled acetylcysteine dose because Nurse B did not return to her bedside again that night.

The next morning, Nurse A arrived for duty and began a discussion with the secretarial staff. Upon learning that her patient was back in restraints, Nurse A searched out Nurse B, who was about to go off shift.

Nurse A: You had Ms. R put back in restraints? How could you?

Nurse B: What do you mean, how could I? She was screaming and banging her head on the railing!

Nurse A: Well, you must not have been able to take care of her. She has some very special needs.

Nurse B: Maybe you think that, but you should never have taken her out of restraints! You got me in trouble for that and you made me look bad.

Nurse A: Well, you must not have been doing a good job. Maybe you should go back to school and learn how to be a caring nurse.

At this point, the two nurses were separated for fear that physical violence between them would erupt.

Later that day, Ms. R—who had decided to speak only with Nurse A—revealed to Nurse A that she had missed her last six acetylcysteine doses. The two laughed at the ineptness of Nurse B, who had forgotten to administer the medication. Nurse A called the medical team to inform them of this oversight. The team was already frustrated at the amount of trouble they had in caring for this "psych patient who shouldn't even be on our service—can't the stupid psychiatrists learn how to give Mucomyst and take her on their service?" They came to the floor and cornered Nurse A. The physicians angrily asked her how this could have happened and decided to file a complaint. They told Nurse A, "This is about the kind of nursing care that we've come to expect at this hospital." Nurse A, devastated and crying, went to Ms. R to relate this story and was comforted by her; Ms. R told Nurse A that she was the best nurse in the hospital—"the only person who seems to know anything around here."

That evening, just as the intern was about to leave, Ms. R asked to speak with him. In general, the intern had enjoyed taking care of her; she had been forthright and kind with him and had repeatedly told him that he had a much better manner than his senior resident. She informed him that, while out of restraints last evening, she had taken 15 extra Tylenol tablets that she had hidden in the bedside table. Of note, she had told Nurse A about her repeat overdose that morning, but both had agreed not to tell the medical team because "they would overreact." The intern frantically called his senior resident, who came to Ms. R's bedside. The senior resident began yelling at the patient, telling her that her actions were getting in the way of her medical care and that she needed to be restrained because she was "not going to get in the way of my taking care of patients who have real medical problems!" He ordered intramuscular haloperidol (10 mg) and intramuscular benztropine mesylate (1 mg); Ms. R received these injections and was asleep for the rest of the night.

By the time the psychiatric consultant arrived the next morning, the staff was in an uproar. Nurse A and the intern were fuming about the intramuscular injections given to Ms. R, Nurse B was furious at Nurse A for making her look bad, and the senior resident was angry at everyone for being inept and for causing such problems.

Discussion

Several articles have described general management strategies in the treatment of difficult patients in both inpatient (10–18) and outpatient (19–24) general medical settings. However, there is little in the literature that specifically addresses the use of concepts and skills associated with DBT in the treatment of such patients. Given the intensity of feelings evoked and manifested by difficult patients, and the benefits attributed to DBT in those with borderline personality disorder, it seems appropriate to investigate whether DBT and its underlying principles have relevance to the care of difficult patients in the general hospital. The following discussion of the use of DBT in the treatment of difficult patients in the general hospital is a synthesis of comments from Drs. Huffman and Stern (from the psychiatric consultation service) and Drs. Harley and Lundy (from the outpatient DBT treatment team).

For the purposes of this article, a "difficult patient" will be defined as any patient who causes staff distress or impairment of medical care as the result of emotional dysregulation, intolerance of distress, or interpersonal difficulties (i.e., a patient who displays characteristics of borderline personality disorder). Such patients may not have a formal diagnosis of borderline personality disorder but in the context of medical illness may regress toward maladaptive behaviors commonly seen in those with borderline personality disorder.

CONCEPTS OF DIALECTICAL BEHAVIOR THERAPY

Three concepts that serve as the foundation for DBT can aid in the treatment of difficult patients in the general medical setting. These concepts are the notion of dialectics, the use of behavioral techniques (with a particular focus on schedules of reinforcement), and the teaching of specific coping skills to patients and staff.

The notion of dialectics involves the assumption that within any reality—any person, situation or event—there is polarity, a set of seemingly contradictory opposing forces. Internal synthesis of the previously opposing ideas can lead to resolution of internal conflict and lead to change. Linehan has suggested that many dysfunctional behaviors of people with borderline personality disorder can be understood as "dialectical failures." In other words, these persons have an inability to integrate two opposing feelings, desires, or points of view (2).

As a result, patients with borderline personality disorder often perceive people and feelings in extreme, absolute ways. Treaters may be perceived as either helpful or useless, and moods often feel either euphoric or pitch-black. For these patients, there is little awareness that seemingly contradictory emotions like joy and sadness or love and hate can exist simultaneously or that one person can have both "good" and "bad" qualities. By modeling and discussing the idea of dialectics with such individuals, treaters can help patients to see that opposing points of view and conflicting feelings can stand side by side. In the general hospital, such discussions could repair "splitting" of the nursing staff into good and bad nurses by encouraging the patient to consider that each nurse has both positive and negative qualities. Furthermore, the patient can be encouraged to view events in the hospital as partially bad rather than as horrific.

Behavioral interventions are also crucial in the management of difficult patients. There is a natural schedule of reinforcement on nursing units that works well for most patients but causes trouble for patients who struggle with emotional regulation. This can be illustrated by what transpires when a nurse is called to the bedside. The assumption is made that the patient calls the nurse when in need of something that requires a relatively urgent response. If the nurse is called to the bedside "too often," the patient is told that the nurse should be called only when there is a truly urgent situation.

This can send a familiar message to a borderline patient: the only time you will get attention is when you are in crisis. For outpatients treated with DBT, a different message is sent—patients are encouraged to call their treaters *before* they are in crisis and before they have run out of coping options. In other words, as patients begin to feel emotionally dysregulated, they are instructed to call to ask for help in preventing self-destructive behaviors. Furthermore, if a patient has committed a self-destructive act, the treatment contract states that there will be no contact between therapist and treater for the next 24 hours. This changes the schedule of reinforcement; it moves from inadvertently reinforcing crisis and self-destructive behavior to a schedule that intentionally uses contact with treaters to reinforce asking for help before a crisis occurs. The idea that the patient is to be "trusted" to use contact with the therapist as a resource between sessions engenders a sense of respect and trust that the patient has likely not been offered previously.

Similarly, in the hospital, the schedule of reinforcement needs to be changed. Emotionally dysregulated patients, or those who fear abandonment, will tend to seek reassurance from staff members. Such patients will become more needy and reassurance-seeking when their calls go unanswered. When they are told that they should call only if there is an urgent need, they may create crises to obtain needed attention and reassurance. Just as in the outpatient setting, the use of positive reinforcements like reassurance and attention should be carefully examined so that they are not linked inadvertently to the creation of crises. Furthermore, a relationship based on collaboration and respect for the patient will make it more likely that the patient will act more appropriately.

Finally, the brief teaching of skills aimed at improved coping has a place in the general hospital. DBT skills training focuses on learning and practice of skills in four areas: mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance (Table 1).

While these core strategies were developed for use with outpatients with borderline personality disorder, they can be adapted to help difficult patients in the general hospital. Helping such patients to be

Table 1. Core Skills of Dialectical Behavior Therapy

Skill	Description
Mindfulness	The ability to have an awareness of one's thoughts, feelings, and behaviors in the present. Learning to focus one's mind completely on the current moment's activity (rather than on the past or the future), allowing greater control over attentional and emotional processes. With increased mindfulness, the patient can enhance his or her sense of centeredness and calm in stressful situations.
Interpersonal effectiveness	The process of analyzing an interpersonal situation to identify the patient's goals for that situation. Assertiveness and effective communication skills are taught to maximize the likelihood that a patient's identified goals will be met in that situation while maintaining the quality of the relationship and the patient's self-respect.
Emotional regulation	The identification and labeling of emotions as well as strategies to reduce vulnerability to intense negative feelings and increase the development of positive emotions. Often the simple act of putting a name to a difficult emotion can be quite beneficial by making the emotion feel more tangible and manageable. Once a patient can describe his or her emotional experience, he or she can work toward changing that experience.
Distress tolerance	Learning to bear pain skillfully through a set of strategies (e.g., journal writing and self-soothing) used to tolerate painful situations. These strategies can then be used in place of previously used maladaptive behaviors (e.g., substance use, self-harm, or threats) that can make difficult situations even worse.

more mindful—to focus on the moment, rather than on the events that led to hospitalization or on upcoming medical tests—can help the patient reduce anxiety. Giving patients the skills to become more effective advocates for themselves in interpersonal interactions during the hospitalization can help them get their needs met while being perceived as less burdensome by staff. Helping patients label their emotions—especially those (such as fear, sorrow, and anger) that are common under the stress of an acute medical hospitalization—can help both patients and treaters understand the patient's experience and facilitate appropriate responses. The experience of naming a difficult feeling and talking about it with staff can help a patient to feel more confident in everyone's ability to manage the feeling successfully. Similarly, the experience of clarifying the patient's experience and working together toward a solution can help staff feel more confident that their interventions will be effective and appreciated by the patient. Therefore, by teaching new skills to difficult patients, distress at times of extreme emotion can be minimized and adverse events (whether by patient self-harm, exacerbation of medical illness, or as the result of staff anger) can be drastically reduced.

Use of DBT skills for difficult patient-staff situations

How can patients cope better with the medical environment so that they get the care they deserve and need? In turn, how can staff more effectively manage difficult patients? We present a four-step process for a psychiatric consultant to show how DBT skills can be helpful to patients and staff in several ways (Table 2).

Step 1: Validation

The first step is to repeatedly validate the difficult experience of both the patient and the staff. Neither the patient nor the staff will be able to enter a frame of mind that allows them to consider changing their behavior until they are calmed and feel understood. Both consultant and staff should let a difficult patient know that they are fully aware of how much he or she has suffered and continues to suffer. It would also be important to state things from the patient's point of view, e.g., "I can see that it seems like only some of the people here understand you or are able to help you get what you need. And it must seem like other people have gotten really mad at you or are blaming you."

Similarly, with staff, the consultant needs to help each person feel that his or her "side of the story" is heard. In the hypothetical case vignette, Nurse A might have felt understood if the consultant had said, "Wow! It felt like things were going so well with the patient, and now, all of a sudden, things seem to have taken a turn for the worse in all sorts of ways. That's frustrating." In a similar manner, with Nurse B the consultant might have said, "Wow! It seems like it must have felt like this patient was impossible to please and was out to cause you trouble. Patients like this can be *so* hard to manage."

Such statements need to be made throughout the course of a psychiatric consultation with the

Table 2. Strategies Informed by Dialectical Behavior Therapy for Treating the Difficult Patient

Skill	Description
Validation	Repeated validation of both patient and staff allows both parties to feel supported and understood. This, in turn, makes patients more receptive to treatment recommendations and firm limits and makes caregivers more able to tolerate the distress caused by a difficult patient.
Dialectics	Acknowledging the veracity of two seemingly opposite realities help patients and staff to both feel understood and to recognize that a change in attitudes or behavior must be necessary. Patients can be taught to recognize that they are in extreme distress and that they must change their behavior. Staff can realize that a patient who is splitting them is both very good and very bad.
Behavioral interventions	Reinforcing desired behaviors and extinguishing noxious behaviors (e.g., incessant calls to nurses)—crucial in creating structure for patients and their caregivers.
Teaching of DBT skills	Helping patients tolerate distress, better regulate emotions, and become more interpersonally effective not only allows them to feel better but also helps them to get their needs met more effectively. Staff can also be taught selected skills to help them more effectively tolerate and interact with such patients.

patient and the staff—with each inevitable roadblock all sides will need to feel like their viewpoint has been heard and understood.

STEP 2: USE OF DIALECTICS

The next step is to give staff an opportunity to gain a dialectical view of the difficult patient—to see him or her as both good and bad—and to help the staff realize that they themselves have become part of a dialectic by becoming polarized in their points of view about the patient. DBT emphasizes a dialectical view of the world—that reality is whole and has simultaneous good and bad qualities. Furthermore, change is not an all-or-nothing proposition but instead is a continuous process that often comprises small steps. In DBT, change is also transactional, and a given change may have both good and bad results for a person. Finally, the dialectical world view of DBT holds that one's identity is relational and dynamic and therefore that one's identity does not exist alone as a static, absolute concept but rather is dependent on interpersonal relationships. These ideas allow a person to see that good and bad are not mutually exclusive but in fact coexist with one another throughout life.

Linehan (2) argued that arguments (and splitting) among staff should be viewed as failures of an interpersonal synthesis among staff rather than as something to be blamed on the patient. It would be useful for the psychiatric consultant to sit down as a group with all staff members working with a difficult patient. In such situations, the consultant should, first and foremost, validate the experience of working with this patient and the difficulty of working in a situation where so much emotion and conflict has arisen. The consultant can then acknowledge that some differences in opinion have resulted and should ask each member at the meeting about his or her experience with the patient, listening carefully to each person and mediating any disagreements by validating both sides of the argument. By acknowledging that each staff member's viewpoint is valid and true, the staff can synthesize the viewpoints into a shared and consistent view of the patient. This will allow more consistent care of the patient and help avoid further splitting and conflict.

Once the staff has had some success in synthesizing their view of the patient and has become able to interact with her in a more consistent manner, the difficult patient can be approached with the idea of a dialectic. The patient needs both to be validated and to understand that harmful actions are unacceptable. This could be framed in a dialectic by saying, "We understand how truly awful this situation is for you. You feel ill and out of control and it has seemed hard for you to get what you want. However, I think if you act this way, you won't be able to get what you want and won't get the care that you deserve. Maybe we can think about what it is you want and how we can help you to find a way to get it more effectively." The dialectic is framed as two true statements: you feel awful and you can't act this way. This acknowledges the reality for the patient but also acknowledges a larger reality that must also be addressed. Helping the patient to see both realities can allow him or her deal more effectively with the situation. In the second half of this statement, the patient is offered help in generating new ways to cope more effectively. In offering to think with the patient about the patient's goals and how to reach them effec-

tively, the consultant is positively reinforcing noncrisis behavior and has paved the way for a discussion of interpersonal skills.

STEP 3: BEHAVIORAL INTERVENTIONS

In tandem with the discussion of dialectics, a discussion with staff about behavioral interventions can be initiated. The consultant can discuss how most patients receive positive reinforcement in the form of attention when they call for help and that, usually, this is reasonable and effective. However, the consultant should help the staff to see that an emotionally dysregulated patient may act to create crises to receive this reinforcement if it is not available any other way. Therefore, difficult patients should be rewarded at regular intervals (e.g., visitors at the bedside, removal of restraints) when they demonstrate appropriate behaviors that the staff would like to see increase, including participation in medical care, a lack of self-harm, and appropriate interpersonal interactions. Just as with outpatients in DBT, an agreement about when to call a nurse should be made. Difficult patients should be allowed to call the nursing station when they feel that they are nearing crisis or beginning to feel out of control; they can then receive a brief visit from staff or an as-needed medication. Just as with outpatients, these patients should be informed that if they call too frequently—or not frequently enough—then the plan will have to be reevaluated. In addition, patients should not be rewarded for behaviors that are harmful or disruptive. They should be informed in a nonpunitive, direct manner that if they become belligerent, initiate threats, cause harm to themselves, or disrupt their care, then restraints or medications will be employed. By trusting patients to hold up their end of the bargain, the staff will make an implicit statement of respect for the patients; such gestures of trust and respect can go a long way toward helping these patients maintain control.

STEP 4: TEACHING DBT SKILLS

Once an acute crisis has abated, DBT skills can be taught to prevent and to calm further uprisings between patients and staff (or between treaters). There are ample opportunities to teach skills to both the patient and the staff.

Teaching the Patient. Learning how to tolerate distress is a crucial skill for successfully managing the painful emotions that can often accompany a medical hospitalization. While in the hospital, a patient must cope effectively with a range of potential feelings generated by the problem that precipitated admission and the medical procedures necessary to address the problem. These might include feelings of anxiety, anger, shame, and vulnerability. Such feelings experienced under the stressful conditions of hospitalization can pose a challenge, even to patients whose emotion regulation abilities are generally adequate to meet the events of their daily lives. Thus, patients who have difficulty regulating their emotions at baseline and "well-adjusted" patients who typically have adequate distress tolerance skills can both exhibit emotionally dysregulated behavior under the stress of hospitalization. For both types of patient, hospitalization requires distress tolerance skills, and both can be helped by coaching about how to use them. Given the many stresses of hospitalization, any patient would probably have difficulty attending to in-depth didactic descriptions of skills. Therefore, briefly teaching patients having difficulty coping with painful emotions a few tricks to help them tolerate their high levels of distress would be the best initial approach to take.

For example, the psychiatric consultant might teach paients distress tolerance skills to help them temporarily distance themselves from distressing feelings. One such skill can be the use of distraction. Distraction can be achieved by focusing on thoughts and activities (e.g., writing, reading, or talking on the phone) that temporarily occupy the patient's attention. This can direct attention away from sensations, conversations, and thoughts that reactivate the painful emotion. It is also helpful to encourage self-soothing techniques by identifying comforting, calming things (e.g., a pleasant-smelling lotion or favorite music) that patients can use while in the hospital. One technique that combines distraction and self-soothing is the use of imagery to improve a difficult moment. Patients can be encouraged to imagine a safe, relaxing, comfortable place, including as much sensory detail as possible. With practice, patients can call this image to mind as a way to "ride out" difficult situations and the painful feelings they evoke.

Once patients have learned some effective distress tolerance skills to get through the most difficult moments, they can also learn other skills to further improve their ability to cope with the hospitalization. The type of skill to be learned can be tailored to the specific difficulty experienced by the patient. For example, if the patient in the case vignette continued to ruminate about how she had been treated by Nurse B or by the senior resident, or if she became too focused on worries about the future, it may be useful to teach her mindfulness skills. To introduce the idea of mindfulness, the consultant might sit with the patient and have her calmly and nonjudgmentally observe her own thoughts as they

occur. To assist the patient in letting go of ruminations and maintaining a more present-focused outlook, the consultant might have the patient imagine that her mind is like a conveyor belt and that her thoughts and feelings slowly move along the belt and get placed into a nearby box. In conjunction with this exercise, the consultant could discuss the long-term costs of "getting stuck" in thoughts of past interactions or future events on her awareness of the current moment.

If, on the other hand, a patient is having frequent battles with staff and is unable to advocate effectively for his or her needs, interpersonal effectiveness skills might be useful. The consultant might begin with a discussion of effectiveness. When discussing with the patient the idea that things are difficult, and that the patient cannot always act the way he or she wants (i.e., the dialectic of acceptance and validation versus the need to change), the consultant can ask an important question: what is it that you want to accomplish when you are interacting with the staff? The consultant and patient can then discuss what has been tried in previous interactions. They can examine how effective these methods have been, pointing out how behaviors meant to meet the patient's goals (e.g., to get attention from nursing) ultimately led to the opposite of what was wanted (e.g., no attention from nursing for the rest of a shift). Finally, the consultant can offer to assist in thinking through future interactions with an eye toward helping the patient accomplish his or her goals in ways that work. In our example, the consultant and Ms. R could discuss how her interactions with Nurse B could be somewhat changed; even if she doesn't like Nurse B, she is most likely to get a blanket, some water, or attention from Nurse B if she changes her style of interaction.

If the greatest difficulty is with extreme and rapidly shifting emotions, the patient could learn emotion regulation skills. To introduce these skills, the consultant could discuss the notion of identifying or naming emotions by saying, "So when you're starting to feel out of control, you'll know what you're working with—are you furious, scared, or sad?" Then consultant and patient could work to identify how these emotions come about and how they might be modulated before they get out of control. For instance, the consultant could encourage the patient to observe experiences over the upcoming day to monitor what sorts of events seem to bring on painful feelings and what warning signs signal that painful feelings are about to be "out of control." Once these triggers and warning signs are identified, both patient and staff can use the information to respond earlier in the emotional chain of events, thereby preventing disruptive behavior.

One should keep in mind that not all of these techniques will work for all patients. It will be clear when a patient "takes to" a specific skill and when another skill or technique is less effective. Furthermore, these skills often require significant repetition and time to be learned. Finally, and perhaps most important, the consultant must remember to validate the patient's internal experience of pain as well as any attempts to change. The consultant must express that he or she understands how difficult things have been and what difficult emotions have surfaced. The consultant can tell the patient, "well, of course you feel [angry, hopeless, etc.]. Now, let's see what we can do together to help." Such validation must be frequent and heartfelt if the patient is to take the emotional risks that attempts at change entail. Only after the patient feels validated can the necessary skills be learned and effective changes take place.

Teaching the Staff. The consultant must be mindful that nursing staff on general medical floors often have little experience working with psychiatrically ill patients. Therefore, before introducing specific DBT skills to the staff, it is often useful to provide some brief psychoeducation regarding personality disorders and the management of one's feelings (i.e., countertransference). Groves (11) recommends educating staff about the phenomena of splitting and projective identification seen so frequently in this population. Such education can help the staff to recognize these defenses rather than allowing them to cause staff tension and acting out against the patient.

In addition to providing basic psychoeducation about difficult patients and their defenses, the consultant can also help the staff by teaching specific DBT-based skills to improve interactions with difficult patients and to more effectively communicate with one another.

The fact that a patient does not behave like a patient "should" behave will be infuriating to the staff. There will be little appreciation, limited deference, and more testing of rules and boundaries with this patient than with most others. Nurses and others who work closely with the patient will be tempted to respond angrily or punitively as a result of this behavior. In a process that parallels the validation and exploration of goals done with the patient, the consultant can help the staff by acknowledging how difficult their experience has been and then determine what it is that the staff really wants from the patient. The staff, most likely, will want a relatively high level of cooperation and compliance with medical care and fewer requests by the patient (so that others may receive adequate care).

The consultant and the staff can then work together to see how staff can behave (using a combination of schedules of reinforcement and interpersonal effectiveness skills) to get what they want. This will likely include suppressing anger and entitlement when the patient acts either unappreciatively or rudely, and, at times, letting the patient "win" by allowing small infractions of the usual rules in exchange for compliance with major aspects of the treatment. This will be frustrating to treaters, who may feel that the patient needs either to be grateful or completely compliant. However, when framed in a way that emphasizes effectiveness ("What can we do that will cause the least amount of tension and struggle for you with this patient while we are still providing good care?"), it is most likely to be adopted by the staff.

Patients may evoke a variety of feelings in staff and may make staff want to perceive them as very different from themselves (e.g., "She's a psych patient" or "She's crazy"). In some ways this is protective for the staff by avoiding overidentification; in other ways it prevents an alliance or empathy with the patient from developing. By helping staff to develop some understanding of the patient's difficulties, they will be better equipped to interact with the patient in a therapeutic way.

The consultant can encourage staff members to remember periods in their own lives that evoked feelings similar to those the patient is experiencing. By calling upon memories of their own struggles rather than distancing themselves from patients when their behavior is provocative, staff members will almost certainly find themselves able to respond in a more compassionate and effective manner.

This also applies to staff-staff interactions. In our example, if Nurse A had been able to imagine what Nurse B's experience might have been like—getting in trouble as a result of the patient being out of restraints, seeing the patient bang her head, and being devalued by the patient—she might have understood the fear and anger that Nurse B experienced. She would then have been able to communicate with Nurse B more effectively. Likewise, if Nurse B had been able to imagine Nurse A's horror at the patient being restrained after she had worked so hard to build an alliance with the patient and to gain Ms. R's trust and compliance, she might have been better able to appreciate Nurse A's perspective.

Despite numerous therapeutic interventions, the treatment of difficult patients can become frustrating and overwhelming. Behavioral techniques and the use of skills can, at times, seem to lead nowhere. No matter how skillfully a patient or a team of staff members behaves, they won't always get what they want. In these moments, the concept of radical acceptance can be useful. By "radically accepting" a situation, a person completely gives in to the idea that a painful reality exists and accepts that it must be faced as it is. This implies that the person has, for the moment, given up on denial or on ineffective anger and has now changed the focus to tolerating a noxious stimulus. Radical acceptance does not imply approval or liking of the painful situation; rather it is the decision to accept that the pain exists and that, for now, it must be endured.

The consultant can introduce the idea of radical acceptance and suggest that a patient is going to take more of the nursing staff's time, make them angrier, and make them feel more hopeless than they would like. Instead of trying to fight these feelings, nurses can accept them as reality (and possibly laugh at the absurdity of the situation). This does not mean that the nurse should stop trying to find ways to more effectively deal with the patient, but it does provide a "safety valve" when such tactics fail.

When any or all of these DBT skills are ineffective, it may be useful for the consultant to return to the bedside and model the skills for the staff, both for educational purposes and to momentarily relieve the staff from their sense of burden and distress. These skills may have varying degrees of success with different patients, but a consultant's willingness to show up, to support the staff, and to continue to problem-solve with the team generally provides significant relief, even if the patient's behavior persists.

SUMMARY

Theory and skills from DBT can help in the management of difficult patients on the general medical unit. We recommend 1) repeatedly validating the experience of both the patient and the treaters, 2) introducing the idea of dialectics to staff and patients to reduce splitting and extremes of affect, 3) identifying and implementing reasonable behavioral interventions that reward compliance and that do not reward crisis behavior or acting out, and 4) teaching skills that increase tolerance of distress, increase interpersonal effectiveness, and reduce feelings of helplessness. The psychiatric consultant can educate ward staff by using specific cases to outline a general approach to the care of the difficult patient using DBT skills; inservice training with staff at other times can also be performed if the consultant is available and the staff is willing.

Given the limited time available to psychiatric consultants, it would be unlikely that a consultant could apply each of the interventions discussed in the article for a given patient. However, the principles outlined here should prove useful to a wide

variety of patients, and physicians can use portions of these skills to reduce distress and improve the care of many patients. Although the long-term cost effectiveness of such intensive psychiatric consultation with these patients has yet to be determined, the potential improvement of medical care, reduction of staff distress, and relief of suffering that can occur as a result of these interventions would be undeniable benefits of implementing these skills.

Further information and training in the use of DBT is available through the writings of Linehan (2, 3) as well as through more intensive workshops hosted by the Behavioral Technology Transfer Group founded by Linehan (www.behavioraltech.com).

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