**Potential Clinical Presentations**

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| **Presentation** | **What it May Look Like** | **Possible Reasons** | **Initial Approaches** |
| Angry | * Behavioral problems/’acting out’ * Threatens verbally: Threats of violence, threats of self-harm, threats of complaints about clinician * Difficulty tolerating distress which impacts ability to complete tasks * May present as self-sabotaging | * Anger may be a secondary and more comfortable emotion * Pain (physical or emotional) * Trauma * Psychiatric or SUD disorders, including Axis II disorders * Past negative experiences * Defense mechanisms such as projection or displacement | * Set limits and boundaries, including time limits to sessions * Maintain consistent response to limit setting. * Be transparent * Consider a task oriented approach focusing on concrete tasks and deliverable outcomes * Allow the Veteran to guide the pace of assessment, explore gently and don’t push too hard for answers if Veteran is presenting as guarded * Maintain consistency * Maintain good self-care and don’t personalize the anger * Engage in consultation as needed for support |
| Disorganized | * Literal disorganization: lots of papers, difficulty remembering appointments, “spinning their wheels” * Psychological disorganization: disoriented, rambling, unable to have linear conversations | * Medical issues like dehydration, low blood sugar, or UTI * Psychiatric conditions: Psychosis, depression, mania * Substance abuse/Acute intoxication * Dementia or other cognitive disorder (could be related to SUD, age, or other organic cause) | * Assess for immediate safety or medical needs * Create simple and structured plans for achieving goals: break things down * These clients may require shorter, more frequent visits to accomplish tasks * Focus on one task at a time * Help clients keep a calendar, or even just one consistent appointment each week to check in * Consistency and simplicity are key * Consider formal mental health and/or neuropsychology evaluations whenever possible * Monitor changes in presentation: do they sometimes present at more or less organized? What’s different during these encounters? |
| **Presentation** | **What it May Look Like** | **Possible Reasons** | **Initial Approaches** |
| Overly Compliant/Passive | * Eagerly and indiscriminately complies with your suggestions * Appears to place all responsibility for decision making, execution and outcome on to you/others * “Whatever you say”, “You’re the boss” | * Depression or other psychiatric condition * Fear of failure, sometimes based on past experiences * Passive aggressive * Low self-esteem * Genuine appreciation and desire to not “be a bother” | * Work to build confidence and self-efficacy * Encourage the Veteran to take the lead in decision making and accomplishing tasks * Give clients simple and reasonable tasks to complete * Offering choice wherever possible and give space/time to make their choice * Affirm their own contributions to outcomes * Encourage them do the things they can reasonably accomplish on their own * Resist the urge to take over a task if they are unsuccessful or don’t complete it the first time |
| Fearful/Distrustful | * Avoidant behaviors such as missing appointments or not returning calls * Veteran may be guarded in providing even basic information * Veteran may decline assistance despite obvious need | * Psychiatric or SUD disorders, including Axis II disorders * Past negative experiences * Defense mechanisms such as projection or displacement * Trauma * Fear of legal consequences such as incarceration, parole/probation violations, or involuntary hospitalization * Cultural factors/not comfortable asking for or accepting help | * Consider briefer yet more frequent visits * Allow for extended time to build rapport * Be flexible with missed appointments * Provide deliverable outcomes * Allow the Veteran to guide the pace of assessment, explore gently and don’t push too hard for answers if Veteran is presenting as guarded |