**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
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| 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?
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| **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
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| 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
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