SESSION R04

IMPROVING OUTCOMES FOR PATIENTS WITH MENTAL ILLENSS AND PERSONALITY DISORCERS

OHIO HEALTH CARE ASSOCIATION: WINDS OF CHANGE

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OBJECTIVES

Describe strategies to improve treatment outcomes for:

1. Patients with anxiety disorders.
2. Patients with mood disorders.
3. Patients with Trauma and stress-related disorders
4. Patients with Schizophrenia Spectrum and Other Psychotic Disorders
5. Patients with Obsessive-compulsive and related disorders
6. Patients with Personality Disorders

SEVERE MENTAL ILLNESS AND PERSONALITY DISORODERS INTERVENTIONS

Mental Illness and Personality Disorders

- Axis 1- Mental Illness:
  - Pathology- result of intensity and/or rigidity. Includes intellectual disability.
  - Traits deviate from norms
- Axis 2- Personality Disorders
  - Behavioral Continuum- extremes are Personality Disorders, less severe quirks
  - Traits deviate from norms

Mental Illness and Personality Disorders

- Healthy: "gets it", insight, empathic, flexible, confident
- Mild to Moderate Mental Illness: Sometimes "healthy behaviors" and/or defensive
- Personality Disorder: Impaired "healthy behaviors", rigid, doesn't see things from another's viewpoint, perceives environment differently, little if any empathy, inadequate
- Severe Mental Illness: loss of touch with reality

PERSISTENT DEPRESSIVE DISORDER

-A continuum from mild to severe depression

-Includes former Dysthymic Disorder and Major Depression

-Criterion for both still similar

Major Depression Without Psychosis

1. Not Violent
2. Monitor Medication, Mood Level
3. Don't Minimize, Respect
4. Requires a Crisis Plan
5. Provide Support, Positive Feedback, Encouragement
6. Recommend counseling

Major Depression Without Psychosis: Interventions, discussed with Mental Health Professional

- Spiritual Support
- Develop Sense of Hope
- Activate
- Art/Music/Pet Therapy
- Life Review

MILD TO MODERATE DEPRESSION STRATEGIES

-Monitor medication and mood level
-Engage them, empathize
-Provide positive feedback
-Provide support & encouragement
-Recommend counseling

Bipolar Disorder

B-I: Manic or Mixed, severest

B-II: Depressive (most frequent & intense) and Hypomanic- 4 days, no full manic episode (unless med induced)

1. **"Feeling better" may not be true**
2. **Feel like they don't need medications**
3. **Monitor medication**
4. **Supplements: Copper, zinc, magnesium, calcium, chromium, B Vitamins, Omega-3, amino acids, high-dose multivitamins**
5. **Minimize stress**

Schizophrenia

- Late adolescent-young adult onset, lose touch reality, at least one: Hallucinations, Delusions, Disorganized Speech (often faulty ABC's)
- Require medication
- Need good MD to differentiate meds side effects From illness
- Separate person from the illness

Schizophrenia- Interventions

- Don't assume anything
- Develop trust relationship
- Use some symptom based interventions- concrete
- Use smaller behavioral goals
- Don't expect too much too soon

Schizoaffective Disorder (psychcentral.com/disorders/sx4t.htm) and DSM V


- **Definition- both affect and thought**
- **Major Mood episode continually present**
- **Difficult to Treat- depressed, suicidal, refuse meds because paranoia, irrational thoughts/fears**
- **Holistic Treatment- social, welfare, biological, psychological**

Schizoaffective Disorder (psychcentral.com/disorders/sx4t.htm)

- **Monitor required medications**
- **Don't reduce meds for 3-6 months after mental hospital discharge**
- **Need to treat side effects**
- **Need a safe, stabilized environment**
- **Problem Solving- may need help with coping skills/deal problems**
- **Be present oriented- concrete skills for daily coping**

Anxiety Disorders

1. Panic Attacks
2. Generalized Anxiety

Generalized Anxiety Disorder

- Chronic, mild to moderate, 2 years
- Functions, but not as well as others
- May be on medication
- More easily distracted
- May need help to calm and relax
- May need referral for counseling

PANIC DISORDER WITH PANIC ATTACKS

Definition:

- Sudden periods of intense anxiety, no obvious cause
- Increasing physiological arousal and fear
- With cognitive and somatic symptoms
- Appears to be a type of fight or flight response involving adrenaline rush
- Often shortness of breath and chest pain the predominant symptoms

Duration: Seconds to minutes

Care For Panic Attacks

- Watch diet: stimulants and other drugs- caffeine, nicotine, Ritalin, SSRI's can cause
- Be positive and supportive
- If one occurs, help relax and slow breathing rate
- Consider anti-anxiety medication

TRAUMA AND STRESS RELATED DISORDERS: PTSD

- No longer an anxiety disorder
- Avoidance, emotional numbing
- Increased arousal- sleep, anger, hyper-vigilance, concentration, easily startled
- Memory and feelings are disconnected
- May re-experience the traumatic event

PTSD

- Populations At Risk: military, natural disasters, traumatic experiences, older adults.

- Most common: military combat
- German study: PTSD is more common as we age, should be screened (odds for trauma exposure almost four times higher- study of 3170 age 44+)

- Older adults likely to have PTSD with other psychiatric conditions (anxiety, depression)

PTSD *CARE* & SYMPTOMS

Need calm, supportive environment

May need medication- depression/anxiety/beta blocker

Other symptoms- substance abuse, depression, suicide, mistrust, somatic complaints

PTSD CARE: CANINE THERAPY

Beta-endorphins and Oxytocin formed when nurturing others or others nurture you- causes positive side effects:

- **Lower blood pressure**
- **Reducing medication needed**
- **Reducing physical pain**
- **Reducing boredom and depression**
- **Decreases isolation, alienation, increases socialization**
- **Encourages communication**
- **Provides comfort, reduces anxiety**
- **Helps overcome emotional disorders**

EMOTIONAL BENEFITS OF HAVING A COMPANION DOG

- Brings out feelings of love
- Good companions
- When trained, take orders well- gives control
- Closeness often found in combat between veteran and his buddies often lost when they come home. A canine companion provides closeness again.

TRAUMATIC BRAIN INJURY (TBI) TBI 2015

- Moderate/Severe often readily apparent, one or more major physical impairments
- Mild may not be diagnosed until have problems with once easy tasks/social situations.
- Symptoms often related to specific areas of the brain:

  Frontal Lobes = lose higher cognitive functions, judgment/reasoning, decision making, inhibitions

  Cerebellum = loss of coordination and balance

  Brainstem = breathing, heart rate, arousal
- Sometimes TBI = symptoms mental illness apparent, result of TBI (no mental illness present prior to TBI)

TBI PROACTIVE MEASURES Taken from © TBI 2015

- Develop trust relationships
- Understand behaviors and causes
- Recognize, respond to precursors
- Manage own behavior, not others
- Minimize the inappropriate behavior
- Recognize a neurological problem, not a personal issue.
- Remain calm
- Be flexible

DEALING WITH PATIENTS WITH TBI: TBI and VIOLENCE

- Maintain a Calm Environment
- Explain before you act
- Use pacifying words/calming body language
- Space and Safety, direct access to door
- Some eye contact, but avoid staring

OBSESSIVE-COMPULSIVE & OTHER RELATED DISORDERS

- No longer an anxiety disorder
- Intrusive thoughts (obsessions) cause anxiety and repetitive behavior reduces anxiety (compulsions)
- Excessively repetitive behaviors interfere with life
- Common compulsive behaviors include washing, repeating, checking, touching, counting, hoarding, sexual or aggressive impulses, things "just so,"
- Common obsessive thoughts include forbidden thoughts (sexual/religious), contamination, losing control, other unwanted intrusive thoughts, doubters
- Recognize thoughts/actions irrational

OCD CARE

-Become familiar with obsessions and compulsions

-Minimize situations which might trigger obsessive thinking and compulsive behavior

-Monitor medication: anti-depressants

Personality Disorders

Borderline

Antisocial

Narcissistic

Histrionic

Obsessive-Compulsive

Borderline

DEFINITION: lifelong (adolescent onset), pervasive, self-defeating, intense, erratic moods, resistant to change, impulsive, abandonment issues, comorbidity, failed ability to regulate emotions

BPD IS A COMBINATION OF: © 1991 Linehan

1) **Invalidation during childhood- severe abuse**
2) **Biologically factors = overreact to emotional stimulation. Level of arousal rises more rapidly, peaks higher & takes longer to return to baseline = crises & extreme emotions**
3) **Invalidation = lack of skills to deal with sudden emotional surges**

Borderline Personality Disorder Characteristics

*About 80% engage in SIB
*10% complete suicide
*Approximately ¾ are women
*Often set up providers to reject them
*Emotionally needy/draining
*Must involve mental health professional- use of DBT cuts suicidal rate by half

Borderline Personality Disorder- Care ©2004 Warner

1. Assess/document risk/protective factors for SIB
2. Stability and consistency crucial
3. Don't personalize
4. Remain calm

Borderline Personality Disorder © 2004 Warner

BPD Clients See SIB

Solving Problems

1) Regulates emotions (feel better)

2) Communicates pain/anger

3) Relieves dissociation-"I feel real"

4) Relieves racing/obsessive thoughts

5) Maintains control (of pain or their bodies- "Can't control feelings, but I can control that"

Research

Linehan–Comorbidity of BPD

Axis 1 diagnosis lifetime incidence:

•Major depression	96%**
• Substance dependence	96.5%*
•Post Traumatic Stress	56.5%*
•Panic disorder	52%*
•Social phobia	21%
•Obsessive Compulsive	24%
•Eating disorder	25%

Borderline VS Bipolar

Borderline	*Bipolar*
5 Million	2.3 Million
2-3% Adults	1.2% Adults
3X More Females	Overall Same Male/Female
	Higher *incidence* of rapid cycling, cyclothymic in women
Intense Emotions for Short Periods	Mood States Last Longer
Lacks Empathy	Can Empathize
Insightless	Capable of Insight
Daily Erratic Moods	Episodic Moods
Not Always Talkative	Highly Verbal at Times

Antisocial © 2009 Ekleberry

Disregard other's rights, repeated assaults, people users, predatory, liars, grandiose, impulsive, easily provoked, reckless, irresponsible, no remorse, gracious to abusive/cruel, anti-authority, detached, seek danger. Genetic.

Antisocial Personality Disorder Characteristics and Care © 2009 Ekleberry

- -Drug knowledge/seeking behavior
- -Can be friendly, but only surface
- -Establishing trust-confidentiality
- -Avoid getting in middle with authorities

Narcissistic © 2009 Ekleberry

Examples: Braggers, sees self as a victim, finds faults, insensitive, arrogant, dominant

- *Grandiosity:* need admiration, inflated self-image, *self-importance,* uses others, lacks empathy, feels entitled without achieving, fantasies about self

Narcissistic- Characteristics and Care © 2009 Ekleberry

-*High % criminal justice:* surprised by reaction to their behavior

-*Inflexible:* envious, easily hurt, anti-rules/restraint, impatient, abrasive, abrupt

-*Avoid shame and humiliation-* depression/rage can result

-*Need attention- avoid excessive amount*

Histrionic © 2009 Ekleberry

- 2/3's meet criterion for antisocial PD
- Dramatic, intense, erratic emotions
- Shallow, attention seeking, social, beauty
- Powerless, fearful, multiple poor attachments
- Mood swings, anxious, defensive
- Lack insigt
- Can dissociate with severe anxiety

Histrionic Personality Disorder Characteristics and Care

-Examples: Flashy dresser, center of attention, "life of party", flirtatious, interrupts/dominates, exaggerates.

-Want: rescue/admiration from provider, this reduces anxiety from poor self-esteem

-Needs:

1) Emotional support
2) Avoid close personal relationship
3) Remain calm and objective

OBSESSIVE-COMPULSIVE PERSONALITY DISORDER- CHARACTERISTICS AND CARE

- **Preoccupied with details, lists, rules, orderliness, perfectionism, mental and interpersonal control at the expense of flexibility and openness.**
- **View their thinking and behavior as "normal"**
- **Very resistant to treatment or changing their behavior or thinking.**
- **Minimize situations- obsessions, compulsions**

DIFFERENTIAL DIAGNOSIS: OCD AND OCPD

OCD	OCPD
many rituals	few if any rituals
problem awareness	behavior/thinking OK
want to get better	don't want treatment

INTERVENTIONS FOR PATIENTS WITH PERSONALITY DISORDERS © 2007 Bland

- Constant vigilance re: suicide, parasuicide, drug use, violence
- May require mental health/psychiatric nurse consultation
- A mental health plan with limits must be established and enforced by all staff re:

-Limits- set firm and consistent ones

-Verbal Abuse- patient has difficulty with anger & emotions, impulsivity. Don't personalize, limit patient demands

INTERVENTIONS FOR PATIENTS WITH PERSONALITY DISORDERS © 2007 Bland

-Provide security, safe, calm setting.

-Minimize stress, conflicts, think before you speak.

-Remain calm and avoid getting upset.

-Prevent manipulating/splitting staff- patients split nurses: "good" & "bad."

-Benefit from on-going Case Management.

Personality Disorders: Treatment With Dialectical Behavior Therapy © 1991 Linehan

- Psychosocial approach
- One individual therapy session per week (and phone)
- One 2 ½ hour group session per week- to acquire behavioral, emotional skills

MEDICATION AND TREATMENT NONCOMPLIANCE

-Cultural belief system
-Developmentally based- age, regression
-Personality based- oppositional, negative
-Knowledge based- deficit, internet
-Grief based- denial, anger
-Mental health based- depression, anxiety, psychotic, personality, cognitive
-Medical based- dementia, delirium, side effects
-Medication/treatment too expensive?

HEALTHCARE VIOLENCE WITH ABUSED DRUGS

adapted from © 2001 Boersma

Substance	Risk Level
• Alcohol	moderate, *W*
• Ketamine	moderate
• Opiates	low
• Cannabis	low/moderate
• Barbiturates	low/moderate, *W*
• Anxiolytics	moderate, *W*
• PCP and analogs	*high*
• Hallucinogens	moderate
• Amphetamines, Ritalin, Methamphetamines, Cocaine	*high*

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