

SESSION R04

IMPROVING OUTCOMES FOR PATIENTS WITH MENTAL ILLNESS AND PERSONALITY DISORDERS

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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

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SEVERE MENTAL ILLNESS AND PERSONALITY DISORDERS INTERVENTIONS

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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

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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

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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

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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

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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

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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

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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

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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

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Anxiety Disorders



1. Panic Attacks
2. Generalized Anxiety

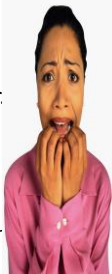
Generalized Anxiety Disorder

- 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**

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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

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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.

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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)

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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

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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

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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



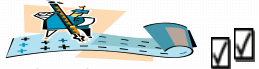
Narcissistic



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

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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

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Borderline Personality Disorder Characteristics

© 2004 Warner

- *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

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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”

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

5 Million
2-3% Adults
3X More Females

Intense Emotions for
Short Periods

Lacks Empathy

Insightless

Daily Erratic Moods

Not Always Talkative

Bipolar

2.3 Million
1.2% Adults

Overall Same Male/Female

Higher *incidence* of rapid
cycling, cyclothymic in women
Mood States Last Longer

Can Empathize

Capable of Insight

Episodic Moods

Highly Verbal at Times

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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.

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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

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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

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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

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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 insight
- Can dissociate with severe anxiety

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Histrionic Personality Disorder Characteristics and Care

© 2009 Ekleberry, 1995-2008 Long, and 2013 Psych Central

-**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

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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

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DIFFERENTIAL DIAGNOSIS: OCD AND OCPD

OCD

many rituals
problem awareness
want to get better

OCPD

few if any rituals
behavior/thinking OK
don't want treatment

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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

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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.

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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

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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?

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HEALTHCARE VIOLENCE WITH ABUSED DRUGS

adapted from © 2001 Boersma

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

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