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Intricate Conversations: Caring for Clients with Severe Mental Illness

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Intricate Conversations

Caring for Clients with Severe Mental Illness

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Disclosures

- Dr. Chovan has no conflicts of interest to disclose.
- Although not planned, at some point, the discussion may include mention of off-label medication use.

Syllabus

- Introduction & Background
- Severe and Persistent Mental Illness 101
- Challenges to Care
- Intricate Conversations Framework
- Operationalizing the Framework
- Charge to the Profession
- Wrap-Up
Objectives

1. Describe the characteristics of persons living with severe mental illness who intersect with hospice and palliative care, and their communication challenges.
2. Describe the Intricate Conversations framework for understanding the special needs of patients and family members with mental illness.
3. Identify proposed approaches to optimizing quality of life of persons with severe mental illness through Intricate Conversations.

Introduction & Background

GOALS OF CARE / PALLIATIVE CARE PERSPECTIVE

Difficult Conversations
- We try to avoid them
- They are necessary
- Promote appropriate, client-centered care
- Meet the client where they are

Intricate Conversations
- Layers on the special needs of persons with severe mental illness
- Stigma of conversation compounded by stigma of mental illness
- Strengths model
- Meet the client where they are

Scope of the Discussion
- Persons living with severe and persistent mental illness journey along the trajectory of a serious, life-threatening illness.
- Persons for whom mental illness emerges in response to their journey along the trajectory of a serious, life-threatening illness.
Introduction & Background

- The time is now
- Convergence of national energies
  - Quality and cost-effectiveness
  - Persons with terminal and life-threatening illnesses
  - Mentally ill persons
  - Patient-Centered Care
  - Evidence-Based Practice

Comorbidity is the rule rather than the exception.
- elevated symptom burden, functional impairment, decreased length and quality of life, and increased costs.

The pathways causing comorbidity of mental and medical disorders are complex and bidirectional.
- medical disorders may lead to mental ones
- mental conditions may place a person at risk for medical disorders, and
- mental and medical disorders may share common risk factors.

Models that integrate care to treat people with mental health and medical comorbidities have proven effective.
- “The most effective treatment for persons with comorbid mental and medical conditions involves a ‘collaborative care’ approach...”
Introduction & Background

National Energies – Quality & Cost-Effective Healthcare

- US Department of Health and Human Services – Strategic Plan 2014-2018
  - **Strategic Goal 1: Strengthen Health Care**
    A. Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured
    B. Improve health care quality and patient safety
    C. Emphasize primary and preventive care, linked with community prevention services
    D. Reduce the growth of health care costs while promoting high-value, effective care
    E. Ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations
    F. Improve health care and population health through meaningful use of health information technology

Introduction & Background

National Energies – Terminal & Life-Threatening Illnesses

- Institute of Medicine (2014) – *Dying in America*
  1. Ensure access to care when approaching end of life.
  2. Develop and adopt quality standards; tie to reimbursement.
  3. Support specialized training of healthcare professionals.
  4. Support quality care consistent with client values, goals, and informed preferences.
  5. Advocate for and use fact-based information about care of people with advanced serious illness to encourage advance care planning and informed choice based on the needs and values of individuals.

Introduction & Background

National Energies – Caring for persons with mental illness

- National Institute of Mental Health Strategic Research Priorities
  - **Strategic Objective 2: Chart Mental Illness Trajectories to Determine When, Where, and How to Intervene**
  - **Strategic Objective 3: Develop New and Better Interventions that Incorporate the Diverse Needs and Circumstances of People with Mental Illnesses**
  - **Strategy 3.3: Strengthen the application of mental health interventions in diverse care settings by examining community and intervention delivery approaches and how they may affect intervention outcomes.**
Who are our Clients with Severe Mental Illness?

Thought Disorders
- Schizophrenia

Mood & Anxiety Disorders
- Persistent Depressive Disorders
- Bipolar Disorders
- Generalized or Specific Anxiety Disorders
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder

Personality Disorders
- Borderline Personality Disorder
- Dependent Personality Disorder
- Antisocial Personality Disorder

Anxiety
- 48%

Mood
- 25%

Personality
- 24%

Schizophrenia
- 3%

12-month Prevalence in U.S.

[NIMH, 2013]
Severe Mental Illness - Exemplars

Thought Disorders

- Schizophrenia
  - Difficulty identifying reality, thinking clearly, interacting socially; often characterized by paranoia, hallucinations

- Epidemiology
  - Onset: mid- to late-20s; males > females – 4:3

- Traits
  - Positive symptoms (e.g., hallucinations, delusions): SAPS, PSRS, PANSS
  - Negative symptoms (e.g., avolition, anhedonia): NSA-4, BNSS, PANSS
  - Communication difficulties → interpersonal relating

- Impact
  - Morbidity – side effects of antipsychotic drugs, self-medication, disregard for self-care
  - Mortality – life expectancy decreased by 10-25 years

Case Example: Virginia H.

- 52-year-old bereaved mother
- Primary caregiver of son Denny until he died at age 31 from colon cancer
- Dx: schizophrenia, bipolar disorder?
- Tx: Psychiatric treatment → psychotropic medication
- Bereavement client for ~ nine months

Challenges to Care

Thought Disorders

- Schizophrenia
  - Poor insight → impact on autonomy
  - Communication with team and others
  - Veiled descriptors of symptoms
  - Treatment: antipsychotics

Mood & Anxiety Disorders

- Obsessive-Compulsive Disorder
  - Intrusive thoughts that cause uneasiness, apprehension, fear or worry and repetitive behaviors to reduce the anxiety
  - Traits
    - Rituals take up lots of time; good insight into disease; often creates interpersonal difficulties – OCI, Y-BOCS
  - Impact
    - Time consuming rituals, thoughts → negative impact on ability to function in school, work, and family settings.
Case Example: Steve M.
- 45 year-old hospice patient living at home; cared for by his wife of 13 years
- Had 2 daughters, ages 8 and 10
- Described as "workaholic" by wife
- Had been an avid distance runner
- Dx: Lung cancer – Had stopped smoking x 10 yr ago
- Obsessive-Compulsive Disorder – No hx of mental health treatment
- Angry and avoidant/distancing
- Rituals had included repetitive vacuuming of his home office carpet

Challenges to Care
Mood & Anxiety Disorders
- Obsessive-Compulsive Disorder
  - Impact of rituals on time management
  - As functional levels decline, can no longer perform rituals
  - Treatment: SSRIs, anxiolytics; talk therapy

Severe Mental Illness - Exemplars
Personality Disorders
- Borderline Personality Disorder
  - Marked impulsivity; unstable affect, relationships, and self image
  - Traits
    - Black & white thinking; deficits in conflict resolution; MBPDS, ECS
    - Inconsistent interpersonal relationships, manipulative, risk for self harm
  - Impact
    - Evoke strong reactions in caregivers; splitting behaviors, need good boundaries & team approach, multiple hospitalizations, self harm behaviors to "feel something".

Case Example: Nancy C.
- 65 year-old single hospice patient, diagnosed with Stage IV breast cancer, lived alone
- Dx: Borderline Personality Disorder
- Inconsistent past mental health tx and none for past 10 years
- Hx of frequent calls to Triage and On Call service complaining of vague symptoms, refused offers of home visit
- Was difficult for on call to end phone calls – "Don’t hang up on me!"
- Complained that only her primary nurse, Tina, was competent. Consistently demanded that only Tina visit her.
Chovan & Cluxton (2014)

**Challenges to Care**

**Personality Disorders**
- Borderline Personality Disorder
- Splitting behaviors
- Unstable personal relating
- Safety
- Treatment: Dialectical Behavior Therapy

**Additional Challenges to Care**

**Patient Autonomy**
- Patient Self-Determination Act
  - Informed consent
  - Right to refuse any medical treatment
- Advance directives
- Is the patient able to make their own healthcare decisions?
  - Capacity versus Competence
  - Competence is determined by a judge
  - Surrogate decision maker
  - Capacity can be time variant
  - Mental illness can have an impact on insight, judgment, and critical thinking

**Affect**
- mood, impact of mood, mood changes; BDI

**Behaviors**
- safety, rituals, adherence, self-care, self-image, self-respect

**Decision-Making**
- autonomy, epistemic authority, lack of a support structure, hope, goals of care, capacity vs competency, guardian, surrogate, advance directives, code status

**Interpersonal Relationships**
- families are often gone, support structure, trust, respect, guardian, case workers

**Epistemic Authority**
- “Knowledge claims are worthy of regard by listeners and worthy of response by those with a duty to care.” (Rentmeester, 2014)
- May be different from what is commonly held.
- Is in no way an invalid interpretation of reality.
The Intricate Conversations Framework

- Understand your own beliefs & misconceptions
- Build trust and rapport
- Learn about their environment
- Understand features of their mental illness
- Be respectful
- Therapeutic use of self
Intricate Conversations Framework

<table>
<thead>
<tr>
<th>Quality of Life</th>
<th>Physical</th>
<th>Psychological</th>
<th>Social</th>
<th>Spiritual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>Sx, Neg Sx</td>
<td>Pos Sx</td>
<td>Interpers Relations</td>
<td>No Fear</td>
</tr>
<tr>
<td>OCD</td>
<td>Rituals</td>
<td>Obsessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borderline</td>
<td>Self-Harm</td>
<td>B/W Thinking</td>
<td></td>
<td>Splitting</td>
</tr>
</tbody>
</table>

Specific Strategies: Clients with Schizophrenia

- Unhealthy lifestyle choices: less exercise, more smoking, alcohol abuse, and poor diet.
- Antipsychotic medications can adversely affect physical health.
- Some do not willingly verbalize their pain or related symptomology. PAIN-AD observational tool.
- Listening carefully and interpreting communication is key to symptom management.
- Calm, one issue at a time, intentional use of non-verbs, active listening, clear & direct.
Specific Strategies: Clients with Obsessive Compulsive Disorder

- OCD is chronic and laden with self-doubt and guilt.
- Therapy and pharmacologic treatment works.
- Clients can learn to face their fears and resist compulsions.
- Active listening, body language are reassuring.
- Track progress and anxiety levels: evaluative tools.

Specific Strategies: Clients with Borderline Personality Disorder

- Remember that the client is suffering.
- The client not defined by the borderline personality disorder.
- Tactfully respond to the client’s distress, but along with strict limit-setting
- Recognize splitting behaviors and interrupt them.
- Consider written treatment contracts.
- Engage in your own self-care.
- Use experienced consultants.

Intricate Conversations

1. Persons with SMI have palliative care needs similar to general population
2. Integrate principles of palliative care into all care for people with SMI.
3. Ensure access to care.
4. Tap into the benefits of others to help each other with new situations and with personal and professional clients.
5. Readjust the expectations of the professional caregiver.
6. Mental illness should not reflect on the individual’s value as a person.
7. Maintain therapeutic relationship based on hope, dignity, respect, and valuing the epistemic authority of the client.
8. Underscore non-abandonment with clients.
9. Use evaluative tools to understand the clients’ current world view as well as changes over time.
10. Work with clients to define what quality of life means to them.
11. Develop policies and guidelines to address needs of this population.

(continued)
Intricate Conversations

A framework for caring for persons with severe and persistent mental illness

Considerations:
- personal traits
- traits d/t illness, including safety
- impact of therapies on individual
- impact on caregiver
- respecting individual choice
- pain & symptom management – whole person

We still have a long way to go

Charge to the Profession

"What then should we expect regarding the future of end-of-life care for persons with serious mental illness? The answer should be: 'The same we do for everyone else.'"

Applebaum (2005)

A Final Thought......

"As we improve end of life care for people with serious mental illness, we will learn how to provide better care for all."

### References (1 of 3)


### References (2 of 3)


### References (3 of 3)

40. Journey to Excellence. Mark O’Connell/Healthcare Systems. Columbus, OH.