Developing Psychiatric Competencies for the Non-psychiatric Nurse

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Psychiatric Conditions seen in a General Hospital

- Thought disordered patient
- Personality disordered patient
- Dementia patient
- Aggressive or difficult patient or family

Axis Diagnosis

- Axis I primary psychiatric condition
- Axis II personality disorder or developmentally disabled
- Axis III medical diagnoses or conditions
- Axis IV current stressors
- Axis V Global Assessment of Functioning

Thought disordered patient

- Conditions that reflect a thought disorder
  - Schizophrenia
  - Delusional disorder
  - Psychotic disorder (brief or long-standing)

Schizophrenia

- Prodromal symptoms start in adolescence or young adulthood
- Affects all levels of the person's life:
  - Relationships
  - Vocational or educational aspects
  - Often abuse substances to self-medicate (esp. marijuana)
- Positive symptoms: hallucinations, paranoia, delusions, disorganized behavior or speech
- Negative symptoms: social withdrawal, limited communication skills, low energy, apathy etc.

Case Study—Schizophrenia

- Peter was a 21yo male who had been admitted to the hospital for an acute appendicitis. He comes with a diagnosis of schizophrenia.
  - The surgeon that is following Peter does not wish to operate at this time so Peter is NPO and started on IV antibiotics. Surgery will be delayed until his appendix is less inflamed.
  - You go by Peter’s room and see him talking to himself. It appears he is hallucinating. What might be the cause of Peter’s increased hallucinations? What medication would be appropriate to offer?
Communication with the patient who is diagnosed with schizophrenia

- There is a cognitive component to schizophrenia, sometimes past learned information can be forgotten or hard to recall
- Stance to the side — direct face to face stance can be seen as threatening
- Use clear, simple communication, processing complex information can be frustrating to the patient
- Likewise, tasks that have multiple steps need to be broken down into manageable pieces

Communication with the patient with a delusion

- A delusion is a fixed false belief.
- The delusion is detailed, specific and usually cannot be reversed
- The patient with a delusion has little patience with anyone who tries to have them abandon their belief
- Often the delusion is not evident immediately because the person has learned that others do not agree, which could lead to a confrontational communication

Case Study—delusional disorder

- James 24y single male was admitted for fractured femur after a MVA. He was recently released from an inpatient psychiatric hospital with a diagnosis of delusional disorder.
- He had been prescribed Risperdal for his condition.
- He believed his parents had sterilized him when he was a child and now he is unable to have children.
- What might be his reply when you tell him you will set up a referral for a urologist?

Communication with the patient who is experiencing a psychotic disorder

- A psychotic disorder can be brief or long-standing.
- Can be the result of medical or psychiatric conditions: metabolic encephalopathy — renal or liver failure, chronic alcohol use
- Reality testing is necessary since psychosis presentation can change
- Always reinforce what the reality situation is (for instance if a patient believes he/she will be injured in the hospital, reassurance that you are there to help is the most important message to convey)

Schizoaffective Disorder

- An uninterrupted period of time which is characterized by schizophrenic symptoms: hallucinations, delusions, disorganized speech or behavior and with either a depressed or manic or mixed cycle.
- A presentation of hallucinations or delusions for at least 2 weeks which are not accompanied by prominent mood symptoms.
- Symptoms meeting criteria for a mood episode are present for substantial period of the illness.

Case Study—Schizoaffective disorder

- J.T. was admitted to the local community hospital for exacerbation of his C.O.P.D. He was transferred from a state facility, where he was committed for treatment for 6 months. The state facility cannot provide acute medical care. He has been refusing to take his Depakote which is his mood stabilizer, and his mood is becoming more and more irritable.
- He does take his antipsychotic medication. He is also receiving antibiotics and IV steroids.
- How would you change the treatment plan?
A mood disordered patient

- Major depression disorder (SIGECAPS)
  - Suicide, Isolated, Guilt, Energy, Concentration, Appetite, Psychomotor, Sleep
- Dysthymic disorder
- The glass is half empty
- Bipolar disorder
- At least one cycle of mania and one cycle of depression
- Anxiety disorder
- Panic disorder with or without agoraphobia

Personality Disordered Patient

Personality disorders are an enduring pattern of inner experience and behavior that deviates markedly from the expectation of the individual's culture.

- Cognition (ways of perceiving or interpreting others or self)
- Affectivity (range, intensity, lability and appropriateness of emotions)
- Interpersonal functioning
- Impulse control

Cluster A

- Cluster A
- Paranoid—a pervasive distrust and suspiciousness of others
- Schizoid—a pervasive pattern of detachment from social relationships
- Schizotypal—a pervasive pattern of social and interpersonal deficits, marked by acute discomfort with close relationships as well as perceptual distortions.

Communication with the with schizoid personality patient

- Fragile emotional equilibrium avoids intimate personal contact
- Poor tolerance for conflict
- Hard to accept dependent involvement as a patient, might delay seeking treatment.
- Respect the person's privacy, focus on technical aspects of treatment.

Communication with the paranoid personality patient

- A trusting relationship between caregiver and patient is essential
- A low-key and friendly attitude without being perceived as being overly intimate will counter the person's paranoid thinking.
- Provide clear and simple explanation of all procedures.

Communication with the schizotypal personality patient

- Reality testing important aspect of communication
- Fragile emotional equilibrium avoids intimate personal contact
- Might delay seeking treatment
- Might develop frank psychosis if under stress of illness
Cluster B

- Histrionic—pervasive and excessive emotionality and attention seeking behavior
- Narcissistic—a pervasive pattern of grandiosity, need for admiration and a lack of empathy
- Anti-social—a pervasive pattern of disregard for and violation of the rights of others, begins in childhood or early adolescence into adulthood
- Borderline—a pervasive pattern of instability in interpersonal relationships

Communication with the Histrionic or Narcissistic Patient

- In a Histrionic patient their self-esteem is heavily centered in their perception of their body image.
- Provide maximum support but avoid entering into a close personal relationship.
- Narcissistic patients try to portray an image of perfection.
- Both personality disorders share their fear of loss of admiration and approval
- Illness represents an assault to their self-esteem

Identifying and Communicating with the anti-social personality patient

- Predominantly male
- Symptoms start before age 15, diagnosis made after age 18.
- Failure to conform to social norms
- Deciitulness
- Impulsivity
- Irritability and/or aggression
- Disregard for the safety of self or others
- Communication should be firm, no-nonsense approach

Identifying the borderline personality patient

- “Fear of abandonment”, chronic feelings of emptiness (e.g., women stay in violent or abusive relationships)
- Unstable interpersonal relationships
- Identity disturbance
- Impulsivity
- Recurrent suicidal behavior
- Affective instability (commonly mistaken for bipolar diagnosis)
- Intense anger (lasting a few hours or days, but not weeks)

Interactions with the borderline personality patient

- Suicide Potential
- Failure of suicidal gestures
- Induced guilt
- Splitting
- Anger and impulsivity
- Self-mutilation
- Means of communication, has no words for feelings, acting out feelings
- Anxiety defenses:
  - splitting
  - projective identification

Treatment plan for borderline personality

- Clear treatment plan for all nursing staff to follow
- Limit time with patient
- Ask for a partner if patient is trying to split staff, splitting won’t happen with a witness
- Be cautious if patient is trying to build up your ego. “No one understands my like you do” “You’re the best nurse on the floor”
- Projective identification—patient with intense feelings projects this on to the other person, becomes fearful and tries to control the other person by behavior or verbal output.
Case Study: Borderline Personality

- Mandy is a 33yo woman with diagnosed borderline personality, she is anxious being in the hospital having a knee arthroscopy.
- She comments to the nurse caring for her that she doesn’t think the nurse cares what happens to her.
- How would you approach this scenario if you were the nurse caring for Mandy?

Mandy’s Projective Identification

- Ask if Mandy is afraid of going home?
- Her projection is her fear of being alone in her apartment after discharge.
- She is looking to have you ask her surgeon if she can stay overnight even though she is medically cleared by PT and the surgeon.
- Some helpful suggestions:
  1) Work out an emergency plan for her to follow if needed after discharge.
  2) Have all important telephone numbers together.
  3) Assure her that you do care about how she manages at home and you will ask the surgeon for a referral to a home care agency to check on her at home.

The Patient with Dementia

- Dementia: Classified as a cognitive disorder. Development of multiple cognitive deficits manifested by both:
  1) Memory impairment: (inability to learn new information or recall previously learned info)
  2) At least one of the following cognitive disturbances:
     - Aphasia (language)
     - Apraxia (motor disturbances)
     - Agnosia (recognition or identification)
     - Executive Functioning (planning, organizing, sequencing, abstracting)

Types of Dementia

- Vascular
- Lewy Body
- Substance or Medically Induced
- Alzheimer’s

Cognitive Assessment Tools

- Montreal Cognitive Assessment (MoCA)*
- Mini-Mental Status Exam (MMSE)*
- Mini-Cog or Clock Drawing Test*

*Refer to handouts

Vascular Dementia

- 15% of all dementias
- Risk factors: hypertension, cardiac disease, diabetes, strokes
- Characteristics: abrupt onset, stepwise deterioration
- 2 forms:
  1) multi-infarct—completed strokes in cortical and sub-cortical areas
  2) small- vessel disease and microangiopathy of chronic risk factors (HTN, DB, smoking and hyperlipidemia)
- Presentation: diminished attention, prolonged response latency, apathy, disinhibition, behavioral manifestations vary depending on vascular areas involved.
Lewy Body Dementia

- Characteristics
  - 1) rapid onset
  - 2) fluctuating course
- Presentation
  - Visual hallucinations
  - Parkinsonian symptoms
  - Delirium
  - Sensitivity to extrapyramidal symptoms of antipsychotic medication
  - Lewy Bodies seen on CT scan or MRI in cerebral cortex

Causes of Medically Induced Dementia

- Intracranial lesions (tumor, hydrocephalus, TBI)
- Metabolic (renal or liver failures, dehydration, electrolyte imbalances, etc)
- Endocrinopathies (thyroid, adrenal, parathyroid, pituitary diseases)
- Deficiencies (vitamin deficiencies)
- Infections (syphilis, AIDS, chronic meningitis, cerebral abscesses)
- Heavy metal poisoning (lead, arsenic, thallium, mercury)
- Collagen-vascular disease (SLE, temporal arteritis, sarcoidosis)
- Drug toxicity (alcohol, substance abuse, anticholinergics, etc)

Alzheimer’s Dementia (AD)

- Neurodegenerative disease of the brain
- Average duration of 8-10 years between onset and death
- Divided into 3 stages
  1) Early stage – ≥ 18 on MMSE (judgement and ADLs intact)
  2) Moderate stage – 12 to 18 on MMSE (assist w/ADLs and supervision)
  3) Severe stage – < 12 on MMSE (completely dependent)

Alzheimer’s Dementia Presentation

- Progression of the disease
  - Short term memory the earliest manifestation
    - Mild aphasia
  - Impaired visuospatial ability
    - Fluent aphasia, constructional apraxia
  - Calculations, reasoning, judgement and executive functioning
    - Behavioral aggression, agitation, psychosis and personality change
- Diagnosis based on clinical presentation and exclusion of other causes

How to communicate with a patient with Alzheimer’s dementia

- Before speaking
  - Minimize distractions
  - Approach from the front calm and friendly
  - Make eye contact
  - If upset, frustrated or angry communicate at another time
- How to speak
  - Slow and clear
  - Visual cues if possible
  - Avoid complicated explanations
  - Encourage participation
  - Keep choices simple
  - Use humor if possible

What to say to a patient with Alzheimer’s dementia

- What to say or not to say
  - Be positive, don’t argue
  - Do not raise your voice
  - Avoid asking questions that require short-term memory recall
  - If poorly understood, use different words to get your message across
  - Avoid direct confrontation, confusion can occur about facts, true or not true
  - Change the subject if patient becomes upset, frustrated or agitated
Body Language and the patient with Alzheimer’s dementia

- Use gentle touch to communicate care, and provide positive reassurance
- Don’t stand too close, could be intimidating
- Get at the same physical level or lower
- Watch person’s body language
- Listen for emotional content in body language
- Singing and music can help calm a person with Alzheimer’s disease.

Aggressive and Violence in Healthcare

- Bureau of Labor Statistics 2012 estimated 15.1 injuries for each 10,000 full-time workers – probably an underestimate.

Identify Potential Aggression and Healthcare Violence Potential

- Risk factors for violence:
  1. Clinical
     - Patient, visitor, family member or other persons
     - Under the influence, history of violence or history in criminal justice
  2. Environmental
     - Layout, redesign or amenities
     - Lack of parking, extended wait times
  3. Organizational
     - Inadequate security, reduced staffing and violence training

Disruptive, Impulse control and Conduct Disorders

- DSM-5 – brought together disorders previously seen in childhood
- Defined as: difficult, disruptive, aggressive or anti-social behavior associate with physical or verbal injury to self, others, objects or with violating the rights of others
- Behaviors can be: defensive, premeditated or impulsive
- Research is lacking
- No approved drugs for treatment.

Oppositional Defiance D/O (ODD), Intermittent Explosive D/O (IED), Conduct D/O (CD)

- ODD: irritability, anger, defiance and temper describe the attributes (methylphenidate or stimulants and individual therapy effective but only with patients with comorbid ADHD)
- IED: recurrent, significant outbursts of aggression (fluoxetine, oxcarbazepine and CBT can reduce symptom severity)
- CD: repeated aggressive harm to others or animals, property damage, deceitfulness, theft or serious violations of rules, usually male (lithium and haloperidol showed significant improvement, however both can lead to decrease in cognitive functioning)

Techniques for Difficult Patients or Families

- Active Listening
  - Stop and listen to what is being said
  - Give patients or families some control
- Ask Questions
  - Find out what is really bothering the patient or family
- Stay professional
  - Treat the family as you would like yourself or family treated
Questions?