“Freud, Frailty and Families”: Managing Psychiatric Patients with Other Complexity in the Community

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Objectives

• Describe common psychiatric problems that complicate providing optimal homecare
• Describe the reasons why these psychiatric problems present challenges to community-based care
• List management strategies for patients with complex psychiatric problems in the community
• Case One
  – 75 year-old female who lives alone in a home in an older neighborhood. She has been cognitively intact in past evaluations. Her husband died eight months ago. She has the support of her children, but both live out of town. So far, she has refused their efforts to move her near them.
  – Over the last two months she has gown more noncompliant with medications and hygiene, exhibited weight loss and seems more confused when visited by her home health aides. Her house is disheveled. She no longer reads the paper or calls her friends. She has not been to church in months.
Depression

• Case One
  – The patient appears easily distracted and has a flat expression. She denies depression and refuses any treatment along these lines. When you ask her if life is worth living she shrugs her shoulders. However, the patient assertively denies suicidal thoughts.
  – Her posture is slumped and she moves slowly. When doing screening tests she displays little effort. Her Mini Mental State Exam score is 22/30. It had been 26/30 four months ago. She draws a clock with little trouble. Her Geriatric Depression Scale (GDS) score is positive (8/15).
Depression

• Meets criteria for Major Depressive Disorder
  – Denies depressed mood, however
    • Loss of interest, appetite/weight change, low energy, attention
      problems, hopelessness, psychomotor retardation, blank affect
  – GDS positive score
  – May have another cause for depression
    • Grief
    • Cognitive decline
    • Medication noncompliance
      – Misuse/overuse propranolol, e.g.
    • Undertreated medical condition
      – Hypothyroidism lead to depressed mood, cognitive decline, e.g.
Challenges to Care

• Ageism
  – Old people are likely to be depressed
    • “I would feel like that, too.”
    • Not a fatalistic condition

• Recognizing illness
  – Insight
    • Depression can color your ability to recognize your mood
    • Lack of motivation to be treated in depressed patients
  – Noncompliance
    • Hopelessness may foster passive suicide
Challenges to Care

- **Obtaining treatment**
  - Availability of specialized providers
    - Few geriatric psychiatrists
  - Social network
    - May be uninvolved
    - May be limited in number or availability
  - Transportation
    - Driving may not be an option
      - Alternatives may expensive or hard to schedule
      - Home visits unlikely with most providers
Challenges to Care

• Refuses treatment
  • Information
    – Has the diagnosis and treatment been explained?
  • Capacity
    – Is there evidence of cognitive decline not due to mood?
    – Are they cognitively stable, but seem to lack the motivation to make a decision?
    – Does their negativism color their understanding of risks and benefits?
Challenges to Care

- Even when desiring treatment
  - Depressed patients exhibit poor decision-making
    - Frontal lobe dysfunction noted in depression
      - In areas central to insight and judgment
    - Decisions overly influenced by emotional state
      - Cannot help plan their recovery due to apathy
      - Takes longer to make decisions
      - More conservative with risk
        - Skews their view of reality to the negative
        - “I can’t,” “I won’t,” “I’ll never…”
Management Strategies

• Addressing depression
  – Primary provider
    • Antidepressant treatment
      – More likely to take meds from trusted provider
      – Concern about stress, sleep, appetite, energy
        » Depression is a bad word
    • Health-related issues changed secondary to depression
      – Blood glucose levels, hypertension, e.g.
    • Psychiatric evaluation
      – When antidepressant treatment ineffective
      – When dangerous
      – When medical complications become serious
      – When cognition is involved
        » May require neuropsychological evaluation
Management Strategies

• Addressing depression
  – Psychotherapy

• Approach with caution
  – Like a psychiatrist, such providers are viewed with suspicion in this cohort
  – Many who initially are worrisome eventually benefit
    » Like Grandma Moses new skills can be developed

• Be sure the patient is a therapy candidate
  – Must agree to therapy or it doesn’t work
  – Know whether their cognition is too poor
Management Strategies

• Addressing depression
  – Psychotherapy
    • Office therapist with knowledge of the elderly
      – Optimal if you can get her there
    • VNA mental health nurse
      – Some providers may make home visits
    • Grief therapist may be needed
      – Discuss losses of many types
    • Clergy with therapy training
      – Most palatable option for many patients
        » Psychotherapy without the patient realizing it
Management Strategies

• Addressing depression
  – Patient and family education
    • Important in anticipation of course, adverse events
    • Helps lessen idea of “will power” as source
  – Increase social network
    • Peer interaction, support groups
  – Reintegrate back into previous activities
    • Hobbies, church, clubs, volunteer work
Management Strategies

- Non-compliance
  - Antidepressants
    - Weekly fluoxetine has been helpful in these scenarios
    - Do need someone to be able to help them take the medication
    - Usually requires a history of noncompliance to be reimbursed due to expense
      - Fluoxetine 20mg/d…$17.99/mo
      - Prozac 90mg/w……$143.99/mo
Management Strategies

• Treating non-voluntarily
  – BOMH commitment
    • Diagnosed mental illness
    • Dangerousness
      – Noncompliance with medical care can be serious
      – Neglect most likely in this cohort
  – DPOA
    • Must be able to select someone who would act in their interest
  – Guardianship
    • Emergency guardianship exists
Psychosis

• Case Two
  – 81 year-old male with no history of psychiatric illness, now presents with a three month history of delusions that his neighbors are pumping colorless, odorless poison gas into his house. He has never seen this occur, nor does he know how the gas enters the house, but he is unshakable in his belief.
  – He lives with his wife. She has health problems to a much greater extent than he does. He continues to eat and sleep well and has had no exacerbation of any medical illness.
  – Been to the ER after he called the police about the gas. Delirium workup was negative. Sent home with meds he never took.
Psychosis

• Case Two
  – He seems pleasant during the interview until the issue of the poison is addressed. The patient seems angered that “no one believes (him)” concerning this event. He denies depression or anxiety. Cognitively he screens as unremarkable.
  – The patient refuses any intervention other than calling the police again to report his neighbors. His wife and children are very concerned that he may confront the neighbors. His children also get middle of the night calls occasionally because he can “hear the gas coming in.”
Psychosis

• Meets criteria for Delusional Disorder
  – New-onset
    • Medical evaluation for delirium, dementia proves negative
    • No history of psychosis, such as with schizophrenia, that results in severe long-standing dysfunction
  – Complex, but limited, delusional system
    • Seeks out converts
  – Bizarre delusion
    • Not too likely to happen to anybody
    • Stealing his mail would be nonbizarre
Psychosis

• Worry about mood issues
  – May be the cause of the problem
    • Psychotic depression common in the elderly
    • Caregiver burden leads to adjustment issues
      – Children know who would be the stronger caregiver
      – How much support does he get?
  – May be a result of frustration
    • “No one believes me”
      – Especially formerly trusted sources
        » Family, doctor, police
Challenges to Care

• Recognizing illness
  – No insight into the delusions
    • Therefore, no need for treatment
      – Antipsychotics rarely taken
      – “Just stop the gas.”
  – Long-standing psychotic disorders affect decision-making
    • Even when not psychotic
    • Not too much information about other types
Challenges to Care

• Reaction to the threat
  – Shut off A/C or furnace, close vents
    • Risk for both himself and his wife
  – Multiple inspections of house
    • Taken advantage of financially
  – Confrontation of neighbors
    • Communication is the key
  – Seek legal help
    • Usually not a problem as lawyers do not return the call
  – Police
    • Handle calls looking for concern (BOMH/EPC, APS)
Challenges to Care

• Obtaining treatment
  – Do not start with a psychiatric appointment
    • Unless this is the niece they won’t go
    • Reconfirms the issue of “being crazy”
  – Trusted primary provider
    • Hopefully not soon to be formerly-trusted
    • Easier to address issue initially
  – Social network
    • May be too embarrassed
    • Want things fixed overnight
      – May require some effort on their part to relieve burden or provide frequent reports
Challenges to Care

• Refusing treatment
  – Involuntary commitment can be difficult to obtain
    • Mentally ill but not dangerous
      – No law against that
      – Sometimes efforts to force care can set back treatment
    • Usually either threats to others or self-neglect fills dangerousness criteria
      – Here neglect issues may involve spouse as well
Management Strategies

• Addressing psychosis
  – Primary provider
    • Most trusted advice likely to be followed
      – Attention to the stress of the situation
        » Sleeping, anxiety
        » Validate their distress
      – Antipsychotics
        » “Help with your stress.”
        » Low dose atypical agents
Management Strategies

• Addressing psychosis
  – Psychiatric consultation
    • Curbside may be required
      – Many will not go to the “shrink”
    • Treatments not effective
      – May require novel medication approaches
      – Noncompliance could require a long-acting agent
  • Concern about co-existing mood
    – Antidepressant and antipsychotic combination
    – Electroconvulsive therapy
  • Herald sign for dementia
Management Strategies

• Psychotherapy
  – Not helpful in the treatment of psychosis
  – Supportive therapy can help with stress of the situation
    • Rarely have takers

• Home mental health nurse
  – Can be very important in assessing dysfunction due to delusion
    • Delusional, but not dysfunctional, of less concern

• Family
  – Helps relay information, especially if the patient learns to deny the delusion
Management Strategies

• Expectations of treatment
  – Rarely is this completely resolved
    • Need to convey to providers, social network
  – Looking to encapsulate the delusion
    • No longer spontaneous
    • Usually only spoken about when asked by others
    • Just doesn’t seem to provoke the same level of distress
    • Easily redirected
Personality Disorder

• Case Three
  – 77 year-old white female with a history of weight loss and non-compliance of treatment. The patient has been overusing medications, especially laxatives and anti-anxiety agents. She endorses depression, anxiety, past history of psychosis, pain and memory loss.
  – Her social history is chaotic, with multiple marriages, jobs, moves and psychiatric hospitalizations. She reports she does not know why most of children do not speak to her. She endorses past suicide attempts and relishes her recollections of these events. Her past includes time spent in jail.
Personality Disorder

- **Case Three**
  - She has many medical diagnoses and mentions often she has fibromyalgia and irritable bowel syndrome. Her medication list includes 18 PRNs from 7 MDs. Her medical records vary often with her self-reported history. The records detail a history of alcohol abuse.
  - Currently she is living with a son and daughter-in-law, neither of whom are currently employed. She has frequent verbal altercations with them. The daughter-in-law tells you she has to be moved because “we can’t take much more of this.”
  - She tells you she feels “empty inside.”
Personality Disorder

• Meets criteria for Borderline Personality Disorder
  – Unstable mood, behavior, self-image
    • Emotional chameleons
  – May wane a bit in intensity as one ages
    • But losses and stressors of aging may allow the symptoms to reflower
    • At risk for depression, anxiety even psychosis
Challenges to Care

• Sabotage treatment
  – Extreme worry about abandonment
    • If I am not better you have to take care of me…
  – Varying views of providers as both all good and all bad
    • This can change in an instant

• Wear out their welcome
  – Families
    • After this long, they’ve had enough
    • Suspicious of motives of family who seek to provide care
  – Long-term care
    • No one will take them or keep them
Challenges to Care

• Splitting
  – Pitting people against one another
    • Providers v. family
      – Leads to breakdown of treatment plan
    • One provider against another
      – “Nurse J. said I could have that…”

• Extremes of behavior
  – Self-mutilation and active suicidal ideation replaced by refusal of care, neglect
Challenges to Care

• Countertransference
  – How you feel emotionally about the patient
    • These patients are hard on providers
      – Labor-intensive
      – Spending time putting out fires
    • Your reaction is akin to all others
      – Her life has been filled with making other people feel like you do now
    • Do not feel guilty, pay attention
      – Now I know why the kids don’t talk to you
      – May have a sense the patient has had an awful life, yet you feel little empathy for them
Challenges to Care

- **Structure essential**
  - May be best provided in institutional setting
    - Home or apartment has little external structure
  - But non-stability of workforce is an issue
    - Easy to set one off against another
- **Home healthcare or LTC staff**
  - Get little training on how to deal with personality disorders
    - May fall prey to manipulation
    - Must understand what drives them
Challenges to Care

• Refuse treatment
  – Borderline Personality Disorder has been shown to effect decision-making
    • Delayed processing, decision-making
    • Impulsive, maladaptive choices when risk higher
  – Suicide, or passive suicide attempts bring these patients to our attention
    • Usually BOMH or DPOA/Guardian already established
Management Strategies

• Besides calling in sick a lot…
  – Psychiatric evaluation
    • An essential component
    • Personality disorders commonly develop depression, anxiety, psychosis
      – The symptoms of their personality disorder are their coping mechanisms
      – When they are not able to manipulate the situation these other symptoms develop
      – Treat these symptoms with medication as one normally would
        » Antidepressants for depression, e.g.
Management Strategies

• Psychotherapy
  – Essential for progress
    • Very slow progress the norm
      – May require dialectical behavioral therapy
    • Changing the spark plugs v. the transmission
  – Must be motivated to change
    • Egosyntonic conditions
  – Looking in the mirror
    • See themselves as others do
  – An expert in psychotherapy in the elderly helpful
    • Want someone who has dealt with BPD in the elderly
Management Strategies

• Structure to day-to-day living
  – Will help lessen opportunities for pathological behaviors
  – Imposed structure must be achievable
    • Make sure all participants can do activity on time

• Living at home hard to rigidly schedule
  – Day program
  – Scheduled family contact
  – Regular provider appointments
  – Open communication with those the patient may call in crisis
Management Strategies

• **Education is vital**
  – Helps in determining treatment course, expectations, outcome
  – Understanding may build empathy and foster continued involvement
    • Abandonment anxiety fosters the patient to “test” others to determine their fidelity
    • Attempts to disengage met with more intense illness behavior, crisis behavior
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